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

Demarco King,

Petitioner,

15IWCC0001

vs.

NO: 11 WC 12815

Costco Wholesale,

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 17, 2014, is hereby affirmed and adopted.

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

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

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

DATED: JAN 5 - 2015
o12/17/14
RWW/rm
046

Ruth W. White

Charles J. DeVriendt

Daniel R. Donohoo

15IWCC0001

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

Demarco King
Employee/Petitioner

v.

Costco Wholesale
Employer/Respondent

Case # **11WC 12815**

Consolidated cases:

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Molly Mason**, Arbitrator of the Commission, in the city of **Chicago**, on September 30, 2013. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

15IWCC0001

KING, DEMARCO
Employee/Petitioner

Case# **11WC012815**

COSTCO WHOLESALE
Employer/Respondent

On 10/17/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.15% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1315 DWORKIN AND MACIARIELLO
ADRIAN CHEAIKOS
134 N LASALLE ST SUITE 1515
CHICAGO, IL 60602

0210 GANAN & SHAPIRO PC
MICHELLE L LaFAYETTE
210 W ILLINOIS ST
CHICAGO, IL 60654

FINDINGS

On **12/7/2010**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

Petitioner failed to establish a causal connection between the December 7, 2010 work accident and his current right shoulder condition of ill-being. In light of this finding, the Arbitrator views the remaining disputed issues as moot.

In the year preceding the injury, Petitioner earned **$24,808.16**; the average weekly wage was **$477.08**.

On the date of accident, Petitioner was **22** years of age, ***single*** with **2** dependent children.

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$6,123.43** for other benefits, for a total credit of **$6,123.43**.

Respondent is entitled to a credit of **$5,294.91** under Section 8(j) of the Act.

ORDER

For the reasons set forth in the attached conclusions of law, the Arbitrator finds that Petitioner failed to meet his burden of proof on the issue of causation. The Arbitrator views the remaining disputed issues as moot and makes no findings as to those issues.

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

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

Molly C Mason
Signature of Arbitrator

10/17/13
Date

OCT 17 2013

Demarco King v. Costco Wholesale
11 WC 12815

15IWCC0001

Arbitrator's Findings of Fact

Petitioner was born on July 27, 1988. Arb Exh 2. He testified he began working for Respondent about 1 ½ years before his claimed accident of December 7, 2010. He worked as a stocker, putting various kinds of products on shelves. He used a forklift at times but also lifted products by hand.

Petitioner recalled injuring his right shoulder on two occasions prior to December 7, 2010. When he was about seventeen years old, he fell off of a bicycle, striking his shoulder. He recalled a bruise or lump developing on his shoulder after this accident. [He indicated that the reference to a motorcycle accident in his records is an error. The accident involved a bicycle, not a motorcycle.] He saw a doctor but did not undergo surgery. In June of 2010, he injured his right shoulder while playing basketball. He saw Dr. Tanveer, his personal physician, after this injury. [Dr. Tanveer's records are not in evidence.] At Dr. Tanveer's referral, he then saw Dr. Hilton of Bone & Joint. At Dr. Hilton's recommendation, he wore a sling on his right arm for about six weeks. He did not undergo right shoulder surgery.

Records in evidence show that, at Dr. Tanveer's referral, Petitioner consulted Dr. Hilton on June 21, 2010, with the doctor indicating Petitioner "popped out" his right shoulder two days earlier while playing basketball. Dr. Hilton also noted that Petitioner "has a history of shoulder dislocation occurring on the same shoulder about 3 to 4 years ago." Dr. Hilton indicated that the prior dislocation was treated conservatively, with Petitioner denying any interval history of problems.

Petitioner completed a form on June 21, 2010 indicating he had seen Dr. Tanveer. Petitioner indicated his shoulder "popped out" when he "went to dive for" a basketball and struck his shoulder on the ground. Petitioner also indicated his shoulder "popped back in place on its own" but had been aching ever since. PX 3.

When Dr. Hilton examined Petitioner on June 21, 2010, he noted that Petitioner "tends to hold his right arm and [sic] internally adducted position against the side." He also noted that Petitioner could forward elevate and abduct his shoulder only to 90 degrees secondary to pain. Dr. Hilton obtained right shoulder X-rays. He interpreted the films as showing "a concentric placement of the humeral head within the glenoid" and "no evidence of a bony Bankart type lesion." He diagnosed a right shoulder dislocation. He recommended that Petitioner wear an immobilizer for two to three weeks and then undergo therapy. He indicated he would recommend an MRI if Petitioner remained symptomatic after the therapy. He also indicated he discussed "the possibility of surgery if he continues to have instability symptoms in the future." Dr. Hilton released Petitioner to work with no use of the right arm. He indicated Petitioner should stay off work if this restriction could not be accommodated.

Petitioner returned to Dr. Hilton on July 7, 2010. Dr. Hilton described the reason for the visit as "follow up right shoulder dislocation second episode in the last 10 years." On examination, he noted mild apprehension of the right shoulder but no rotator cuff weakness, negative lift-off testing and negative Speed's testing. He demonstrated various rotator cuff strengthening exercises to Petitioner "for future risk of dislocation." He released Petitioner to full duty as of the following day. PX 1.

Petitioner testified he resumed full duty for Respondent after Dr. Hilton discontinued the sling. He continued performing those duties until his claimed work accident.

Petitioner testified that, on December 7, 2010, he was working in a cooler in Respondent's meat department, lifting boxes of meat onto a shelf that was slightly over his head. The boxes weighed 50 to 80 pounds. Petitioner testified that, when he lifted the third box, he felt a sharp pain in his right shoulder. He dropped the box and grabbed his shoulder. He left the cooler and told his supervisor he "tweaked" his shoulder.

Petitioner testified the accident occurred about two hours before his shift ended. He "gutted it out" during those two hours. The following day, he stayed off work and made an appointment to see a doctor.

On December 13, 2010, Petitioner returned to Bone and Joint Physicians and again saw Dr. Hilton. Petitioner completed a "patient history update" indicating he had seen no health care providers since his last visit. The doctor noted he had last seen Petitioner on July 7, 2010 for a right shoulder dislocation. He recorded the following interval history:

> "Since I have seen [him] he has had at least two episodes of dislocation which he states he has put in by himself. He was injured at work on 12/7/10. He stated he was lifting a hefty box, moving the box on the side he felt a tremendous pop in his shoulder and possibly by his description he may have suffered a dislocation event. He continues to have pain in the shoulder responding to some Tylenol 3."

On right shoulder examination, Dr. Hilton noted no scapular winging, no focal tenderness, a positive Speed's test, a positive apprehension sign and a positive Jobe relocation test.

Dr. Hilton diagnosed right shoulder instability. He ordered an MRI "to investigate the possibility [of a] labral tear." He prescribed Tylenol 3 and instructed Petitioner to stay off work and return to him the following week. PX 1.

Petitioner underwent the recommended right shoulder MRI on December 16, 2010. The MRI, performed without contrast, showed a "Hill-Sachs deformity associated with a cartilaginous Bankart lesion involving the anterior/inferior labrum," a "hyperintense signal in

the superior labrum raising concern for a SLAP tear," and no evidence of rotator cuff tear or tendinosis. PX 2.

Petitioner returned to Dr. Hilton on December 22, 2010. The doctor interpreted the MRI as suggestive of "anterior labral tear with possible involvement of the superior labrum." He referred Petitioner to Dr. DiLella and indicated Dr. DiLella anticipated having to perform surgery. He instructed Petitioner to stay off work. PX 1.

Dr. DiLella first saw Petitioner on December 29, 2010. He noted that Petitioner stated he was lifting a heavy box at work on December 7, 2010 when "his shoulder popped out of position." He also noted that Petitioner complained of "rather significant pain with overhead activity and attempted lifting." He described Petitioner as right-handed.

On right shoulder examination, Dr. DiLella noted no tenderness over the AC joint, negative cross-arm testing, active forward flexion and abduction of 150 degrees, markedly positive apprehension, positive relocation and O'Brien's testing and negative drop arm and "empty can" testing. He reviewed the previous MRI and X-rays.

Dr. DiLella's impression was "right shoulder dislocation with labral tear and Bankart lesion." He addressed treatment options as follows: "Given the fact he is a two-time dislocator in the right shoulder, I would recommend arthroscopic evaluation of the shoulder followed by Bankart and labral repair."

Dr. DiLella completed an "off work" note stating: "above patient off work pending R shoulder surgery for dislocation and labrum tear sustained while at work." PX 1.

On February 10, 2011, Dr. DiLella operated on Petitioner's right shoulder at Ingalls Memorial Hospital.

In his operative report, Dr. DiLella recorded the following history:

> "This patient is a 22-year-old male who sustained an injury to his right shoulder while at work. He sustained an anterior inferior shoulder dislocation while attempting to move some boxes. **He underwent a closed reduction at an outside emergency department.**" (emphasis added)

[The Arbitrator notes that no Emergency Room records are in evidence. The Arbitrator also notes that Dr. Newman, Respondent's examiner, testified he questioned Petitioner as to whether he underwent treatment at an Emergency Room after the work accident, with Petitioner indicating he did not. See further below.] Dr. DiLella went on to indicate that Petitioner opted to undergo surgery because he was "already a 3-time shoulder dislocator on the right side." He noted no rotator cuff pathology and described the posterior labrum as "grossly intact." He dissected the torn anterior labrum off the anterior glenoid face. At the end

of the surgery, he placed Petitioner's right arm in a sling and instructed Petitioner to follow up with him in his office. PX 2.

Petitioner saw Dr. DiLella on February 14, 2011. The doctor reviewed the arthroscopic photographs taken during the surgery. He prescribed therapy and directed Petitioner to return to him in two weeks. PX 1.

Dr. DiLella removed Petitioner's sutures on March 9, 2011 and instructed Petitioner to stay off work and attend therapy. PX 1.

Petitioner underwent an initial physical therapy evaluation at Accelerated Rehabilitation Centers on March 28, 2011. The evaluating therapist noted that Petitioner "reportedly sustained an injury to his R shoulder while lifting boxes at work." The therapist also noted that Petitioner complained of difficulty sleeping, sharp pain with quick motions and overall right shoulder stiffness. The therapist indicated that Petitioner exhibited "minimal post-operative deficits." PX 3.

On April 4, 2011, Petitioner filed an Application for Adjustment of Claim alleging a right shoulder injury of December 7, 2010. Arb Exh 2.

On April 6, 2011, Dr. DiLella described Petitioner as "progressing well through therapy." On right shoulder examination, he noted full active and passive range of motion but some weakness. He rated abduction and forward flexion at 4-/5. He prescribed an additional month of weight training and instructed Petitioner to stay off work. PX 1.

On April 11, 2011, the treating therapist at Accelerated Rehabilitation noted that Petitioner had "progressed well" but was still complaining of difficulty making quick motions such as throwing a ball. PX 3.

On May 4, 2011, Dr. DiLella noted 4+/5 strength testing. He prescribed an additional month of therapy and directed Petitioner to stay off work. PX 1.

On May 5, 2011, the treating therapist at Accelerated Rehabilitation noted that Petitioner was still complaining of pain with certain motions. PX 3.

On June 1, 2011, Dr. DiLella noted that Petitioner had completed therapy and was "satisfied with his results." On right shoulder examination, the doctor noted a full active and passive range of motion, negative Speed's, O'Brien's and Yergason testing and 5/5 strength testing. He described Petitioner as "demonstrat[ing] an excellent surgical result." He released Petitioner to full duty as of June 6, 2011. He directed Petitioner to return to him as needed. PX 1.

Petitioner testified he did not undergo any additional right shoulder treatment after June of 2011.

At Respondent's request, Petitioner saw Dr. Newman of the Illinois Bone and Joint Institute for a Section 12 examination on July 5, 2011. In his report of the same date, Dr. Newman indicated he reviewed records from Drs. Hilton and DiLella, Accelerated Rehabilitation and Ingalls Memorial Hospital in connection with his examination.

Dr. Newman recorded the following history:

> "Mr. King states that he was injured at work on December 7, 2010. He was working at Costco. He was lifting a box and turning when he felt a popping sensation in his shoulder. The shoulder popped out of place and then spontaneously popped back in. He was able to continue to work the rest of that day. The following morning he had increased pain and difficulty moving the shoulder. **He followed up at that time with his primary care physician** who referred him to an orthopedic surgeon, Dr. Hilton. Dr. Hilton saw Mr. King on several occasions and then performed an MRI. [Mr. King] was then referred to Dr. DiLella for definitive treatment. He did not receive any physical therapy or injections. Surgery, however, was recommended." (emphasis added)

The Arbitrator notes that no primary care physician records are in evidence.

Dr. Newman described Petitioner's surgery as "very successful." He noted that Petitioner complained of occasional posterior soreness in his shoulder at the end of a workday but was "able to perform all of his regular work duties without difficulty."

Dr. Newman found Petitioner's past medical history significant for a right shoulder dislocation and spontaneous relocation in 2007, resulting in six weeks off work, and a motorcycle accident of June 2010 "that resulted in another injury to his shoulder, again with what he felt was a dislocation and spontaneous relocation," requiring the use of a sling for eight weeks. Dr. Newman noted that, "throughout [Petitioner's] history, there has been no X-ray documentation of a shoulder dislocation."

On examination, Dr. Newman noted well-healed arthroscopy ports over the right shoulder, a full range of neck motion, no significant right shoulder swelling, a full range of right shoulder motion with some tightness at the extremes of internal and external rotation, negative impingement signs, a negative drop test and negative Speed's and O'Brien's tests. Dr. Newman found no evidence of right shoulder instability.

With respect to Petitioner's surgical outcome, Dr. Newman commented as follows: "it appears that Mr. King has had a very nice result from an anterior labrum repair for recurrent subluxations of his right shoulder." Dr. Newman found no need for additional treatment.

Dr. Newman indicated that he asked Petitioner about the histories set forth in Dr. Hilton's records, with Petitioner denying that he went to an emergency room to have his shoulder relocated after the work accident. Petitioner reported that "he has always experienced a spontaneous reduction after" his dislocation episodes.

Dr. Newman addressed causation as follows:

> "In my opinion, he had an unstable shoulder, which was susceptible to anterior subluxations or dislocations at any time. The fact that he was able to relocate the shoulder when it was dislocated or subluxed without any anesthesia or outside help suggests that the humeral head was sliding over the anterior glenoid right from the beginning. I do not think the episode that he described at work was any different from what he was experiencing before. The mechanism of injury was not consistent with a SLAP lesion. His symptoms have been consistent with anterior instability."

Dr. Newman further opined that Petitioner had an "obviously unstable shoulder . . . which was going to require surgical intervention with or without" the claimed work accident.

Dr. Newman found Petitioner capable of continuing full duty.

Dr. Newman characterized the surgery as reasonable and necessary but unrelated to the claimed work accident. RX 2.

Dr. DiLella gave a deposition on behalf of Petitioner on February 26, 2013. The doctor testified he obtained board certification in orthopedic surgery in 2009. He specializes in sports medicine, which primarily involves knee and shoulder conditions. PX 4 at 4-5. He attended medical school at the Philadelphia College of Osteopathic Medicine and underwent fellowship training in sports medicine thereafter. PX 4 at 6. He is currently affiliated with Ingalls Memorial Hospital. He performs ten to fifteen shoulder surgeries per month. PX 4 at 5-6.

Dr. DiLella testified that his partner, Dr. Hilton, referred Petitioner to him. PX 4 at 7. He first saw Petitioner on December 29, 2010. He probably reviewed Dr. Hilton's records at that initial encounter. PX 4 at 14. Petitioner told him he was lifting a heavy box at work when his right shoulder popped out of position. PX 4 at 7. On initial examination, he noted a positive apprehension sign and a positive relocation test, with both of these potentially indicative of shoulder instability. PX 4 at 8. He reviewed a previous MRI, which confirmed a labral tear. He discussed treatment options, including surgery, with Petitioner. PX 4 at 8. He operated on Petitioner's right shoulder on February 10, 2011. The surgery consisted of an arthroscopy followed by a labral repair and a capsulorraphy, or tightening of the shoulder capsule, done to

prevent recurrent instability. PX 4 at 9. He visualized a labral tear during the surgery. The surgery was successful. PX 4 at 9-10.

Dr. DiLella testified that Petitioner stayed off work and underwent therapy following the surgery. By May 4, 2011, Petitioner's right shoulder motion was excellent and there was no evidence of residual instability. PX 4 at 12. By June 1, 2011, Petitioner had completed therapy and had no complaints. He allowed Petitioner to resume full duty on June 6, 2011. PX 4 at 13. He has not seen Petitioner since June 6, 2011. PX 4 at 13.

Dr. DiLella testified that, while Dr. Hilton planned to have Petitioner undergo an MRI following the basketball injury of June 2010, that MRI apparently did not take place. PX 4 at 14. Dr. Hilton cleared Petitioner to return to full duty as of July 8, 2010. PX 4 at 15-16. Petitioner reported no shoulder pain at that visit. PX 4 at 16.

Dr. DiLella testified that, without serial MRIs, it is "quite difficult to decipher" what pathology pre-existed the work accident and what pathology was caused by the work accident. PX 4 at 16. Petitioner had mild apprehension of his right shoulder on July 7, 2010. It does not appear that Dr. Hilton performed a relocation test that day. PX 4 at 20.

Dr. DiLella testified it would be "unlikely" for a person to dislocate his shoulder and not suffer a labral tear. PX 4 at 20.

Dr. DiLella testified he disagreed with Dr. Hilton's decision to release Petitioner to full duty as of July 8, 2010. He opined that Petitioner "should have had an MRI scan prior to release to work." PX 4 at 21. He cannot explain why the MRI did not take place. PX 4 at 25.

Dr. DiLella testified it is "possible" that the lifting of a heavy box by Petitioner on December 7, 2010 could have caused a right shoulder dislocation. PX 4 at 21-22. He had "no way" to reach an opinion as to whether the dislocation that occurred on December 7, 2010 was more severe than the one that occurred in June 2010. PX 4 at 22-23. He would be "purely speculating" if he rendered an opinion on that issue. PX 4 at 23. While it appears there was a significant difference between the complaints Petitioner voiced on July 7, 2010 and those he voiced on December 29, 2010, pain complaints cannot be correlated with shoulder pathology documented on MRI. PX 4 at 24.

Dr. DiLella opined that the shoulder dislocation of December 7, 2010 led to the surgery he performed but did not necessarily cause the need for the surgery. PX 4 at 26. Without serial MRI scans, he would have to speculate to say whether Petitioner would have been able to continue performing full duty absent the December 7, 2010 dislocation. PX 4 at 27.

Dr. DiLella testified the surgery he performed was reasonable and necessary. PX 4 at 30.

Dr. DiLella acknowledged that the history he obtained is different than the one Dr. Hilton obtained in that Dr. Hilton described Petitioner as lifting a box and moving it to the side.

As to this difference, he commented: "I don't have a firm opinion that simply lifting a box and perhaps rolling it to the side or moving it to the side has any major difference in impact in shoulder pathology." PX 4 at 31.

Dr. DiLella testified it is possible that Petitioner tore his labrum when he dislocated his shoulder in June 2010. PX 4 at 31. He further testified it is "possible but unlikely" that, if Petitioner tore his labrum in June 2010, the symptoms associated with that tear could have resolved by July 7, 2010. PX 4 at 31-32. An MRI would have clearly defined whether a tear occurred in June 2010. PX 4 at 32.

Dr. DiLella testified that he has a standard practice of ordering an MRI for any shoulder dislocator he sees, particularly if that individual is only 22 years old. PX 4 at 33.

Dr. DiLella testified that, despite the good surgical result, Petitioner faces a risk of recurrent instability or dislocation due to his labral tear and prior dislocations. PX 4 at 33. He would not anticipate the need for further treatment in the absence of recurrent instability or injury. PX 4 at 34.

Under cross-examination, Dr. DiLella testified he understands Petitioner had only two dislocation episodes, with the first occurring in June 2010. PX 4 at 35. However, on June 21, 2010, Dr. Hilton noted that Petitioner dislocated the same shoulder three or four years earlier. PX 4 at 35. In June of 2010, Petitioner completed a form indicating his shoulder popped out when he went to dive to the ground while playing basketball. PX 4 at 36. It is not unusual for someone to be able to pop his shoulder back into place. PX 4 at 37. The shoulder joint is a ball-and-socket joint. "In most instances in a young person such as [Petitioner] the labrum will tear as a result of the ball [humeral head] becoming dissociated from the socket." PX 4 at 37-38. A history of a dislocation makes it more likely for another dislocation to occur. PX 4 at 38. In some people, the shoulder joint slides easily in and out of the socket. PX 4 at 38.

Dr. DiLella testified that, on December 13, 2010, Dr. Hilton noted that, since the previous visit, Petitioner had had at least two episodes of dislocation. PX 4 at 39.

Dr. DiLella testified Petitioner did not tell him how much the box weighed. If Petitioner was working by himself and the box weighed over 100 pounds, that might impact his opinion as to whether the lifting caused the dislocation. PX 4 at 41. If Petitioner experienced multiple episodes of instability, that would lead to an increased risk of recurrent instability with simple tasks such as lifting a box. PX 4 at 42. If a patient presents to him following a dislocation, he always orders X-rays to show that the shoulder is back in the proper position. If the patient gives a history of instability or dislocations, it's mandatory to obtain an MRI. PX 4 at 43. He would have ordered an MRI had he seen Petitioner in June 2010. PX 4 at 43. Because no MRI was done at that time, he has no way of knowing whether the labral tear pre-existed the December 7, 2010 dislocation. PX 4 at 43.

On redirect, Dr. DiLella characterized Dr. Hilton's December 7, 2010 history as "unclear" in terms of when the prior dislocations occurred. PX 4 at 45. It is possible to have an asymptomatic labral tear. PX 4 at 45. It is possible Petitioner tore his labrum in June of 2010 but only became symptomatic after the December 7, 2010 dislocation. PX 4 at 46. The record describes Petitioner as asymptomatic as of July 7, 2010. Petitioner's symptoms seemed to increase after the December 7, 2010 incident but, without an MRI, it is impossible to characterize the June 2010 dislocation as minor. PX 4 at 47. Even in a person with recurrent dislocations, it takes some degree of movement of the shoulder for another dislocation to occur. PX 4 at 48. However, in people who are grossly unstable or who have had multiple dislocations, it "really doesn't take very much to pop the shoulder out." PX 4 at 49. Petitioner was not grossly unstable on December 29, 2010. The term "grossly unstable" would imply that the individual was able to pop the shoulder in and out of place at will. That was not true of Petitioner but some of Petitioner's tests were consistent with a labral tear. PX 4 at 49.

Dr. Newman gave a deposition on behalf of Respondent on April 25, 2013. Dr. Newman testified he is board certified in orthopedic surgery. Dep Exh 1. About 20% of his patients have shoulder problems. RX 1 at 5-6.

Dr. Newman testified he reviewed records from Dr. Hilton, Dr. DiLella, Accelerated Physical Therapy and Ingalls Memorial Hospital in connection with his examination of Petitioner. RX 1 at 7. At the examination, Petitioner told he was at work, lifting a box and turning, when he felt his right shoulder pop out of place and then back into place. Petitioner indicated he was able to finish his shift thereafter but had increased pain the following day. RX 1 at 7-8.

Dr. Newman testified that the records he reviewed alluded to previous dislocations and spontaneous relocations in 2007 and 2010. Petitioner indicated he underwent an MRI following the 2007 incident and wore a sling for eight weeks following the 2010 incident. Petitioner could not recall another dislocation that occurred during a basketball game. RX 1 at 9.

Dr. Newman testified that, based on his essentially negative examination, Petitioner obtained a "very nice result" from the surgery Dr. DiLella performed. RX 1 at 11-12. The surgery was appropriate. RX 1 at 12.

Dr. Newman testified that Petitioner's diagnosis before the work accident was "an unstable right shoulder with evidence of, by history, an anterior instability." RX 1 at 13. Ordinarily, the shoulder does not pop out of joint. Once a dislocation has occurred, there is an 80% chance of regaining stability. After the second dislocation, there is about a 50% chance, unless there is also a labral tear, in which case the shoulder is likely to be unstable after even one dislocation. If a person can pop his shoulder in and out at will, the shoulder is likely to be "very unstable." RX 1 at 13-14. A shoulder dislocation is very painful. It is a "major injury." An initial dislocation usually has to be relocated under anesthesia. Subluxation is "sort of a half a dislocation." Petitioner's symptoms were more consistent with a subluxation. RX 1 at 14.

Dr. Newman testified that the December 16, 2010 MRI showed a Hill-Sachs deformity involving the humeral head. This kind of deformity is associated with an anterior dislocation. In Petitioner's case, the Hill-Sachs lesion probably developed years ago. RX 1 at 15. The MRI also showed edema compatible with a bone bruise and hyperintense signal consistent with a cartilaginous Bankart lesion. The rotator cuff and biceps tendon were intact. There was a "little bit of arthritis" in the AC joint and no evidence of an effusion. RX 1 at 15. If a shoulder dislocates and the dislocation is associated with a labral tear, "that's a major episode" but, in Petitioner's case, the MRI showed no evidence of a severe acute injury. RX 1 at 16.

Dr. Newman testified that the Hill-Sachs deformity pre-existed the work accident because it was "also associated with degenerative cystic changes which indicate chronicity." It takes a long time for such changes to develop. RX 1 at 16-17. The abnormalities shown on MRI brought about the need for surgery. RX 1 at 17. The surgery that Dr. DiLella performed was "not at all related" to the December 7, 2010 work accident, based on the history and MRI. If Petitioner had experienced a SLAP lesion on December 7, 2010, he would not have continued working that day. It is possible to dislocate the shoulder without tearing the labrum but it is not possible to dislocate the shoulder more than once without tearing the labrum. RX 1 at 18. If Petitioner had torn his labrum on December 7, 2010, the MRI would have shown fluid in the joint due to inflammation and the bursa would have probably shown evidence of inflammation. RX 1 at 19. The surgery was elective, in some respects. Petitioner could have chosen to go on living with recurrent dislocations. The surgery was appropriate but not absolutely necessary. RX 1 at 20.

Under cross-examination, Dr. Newman testified Petitioner's job consisted of lifting boxes and stocking shelves. Petitioner did not indicate whether he continued performing these specific duties after the accident. RX 1 at 21. He views Petitioner's shoulder as grossly unstable because of the fact that it came out and popped back in spontaneously. "A stable shoulder that dislocates frequently requires a general anesthetic with more than one person pulling on it to put it back into place." RX 1 at 22. No X-ray was taken showing the shoulder to be out of place. RX 1 at 22. If a person makes a relatively simple move, such as lifting a box, and experiences a dislocation, the dislocation would not be considered spontaneous. RX 1 at 23. "Lifting a box does not exert a force on the shoulder that would cause a dislocation." RX 1 at 23. Petitioner could have subluxed his shoulder, however, because his shoulder was unstable. RX 1 at 24.

Dr. Newman testified he did not review any records in connection with the motorcycle injury. RX 1 at 25, 31.

Dr. Newman testified that the radiologist suspected a SLAP tear but such tears are difficult to diagnose via MRI, unless you use dye. Dr. DiLella did not repair a SLAP lesion. RX 1 at 28. If Dr. DiLella saw a SLAP lesion, he did not fix it. In Dr. Newman's opinion, Dr. DiLella did not fix a SLAP lesion because the lesion was not there. RX 1 at 28. Even if Petitioner took anti-inflammatories during the interval between the work accident and the MRI, that would not cause blood to be absorbed. If the labrum tore on December 7, 2010, there would have been

blood in the joint but no blood was noted. RX 1 at 30. The bone marrow edema shown on the MRI could have been caused by an acute injury or by the shoulder going out over the anterior glenoid. RX 1 at 32. Petitioner had an injury on December 7, 2010 but the injury consisted of a subluxation, not an acute dislocation or labral tear. RX 1 at 32-33. The motorcycle and basketball injuries were far more injurious than the work accident. RX 1 at 35. The apprehension sign is the pivotal test used to confirm instability. Petitioner had a positive apprehension sign before the work accident. RX 1 at 38.

Dr. Newman testified he charges $1,000 for depositions. He performs about six shoulder surgeries per month. RX 1 at 40. Of the medical-legal cases he works on, about 80% are for claimants. RX 1 at 40. He has no recollection of previously working with Respondent's counsel. RX 1 at 40.

At the hearing, Petitioner testified he is now 25 years old. He saw a doctor at Bone and Joint Specialists in June 2010 because he injured his shoulder while playing basketball. At the doctor's recommendation, he wore a sling for about six weeks. He stayed off work during the time he wore the sling. There are still a few activities he cannot perform, due to his shoulder. He can no longer play basketball, football or baseball. Nor can he bowl. He cannot lift his children overhead. He has some difficulty reaching overhead to place something on a shelf. He no longer works for Respondent. He is a truck driver. He notices irritation in his shoulder when he has to sit for a long time. He did not injure his shoulder between the basketball injury and the work accident. After he stopped wearing the sling, he did not undergo any additional shoulder treatment before the work accident. He has not undergone any additional shoulder care since June of 2011. He believes Aetna, his group carrier, paid his medical bills. He received short-term disability benefits while he was off work. He did not undergo shoulder surgery after either the bicycle accident or the basketball accident. Once his sling was removed in 2010, and he returned to work, he performed full duty before his work accident. Some of the food items he had to stock came in stacks or bundles. The items he lifted weighed between 40 and 80 pounds. He had no trouble stocking before his work accident. On December 7, 2010, he worked for about two hours after his accident but the work he performed consisted solely of sweeping. He "maybe" experienced another shoulder-related incident between the basketball injury and the work accident.

Under cross-examination, Petitioner testified he first injured his right shoulder while riding a bicycle. He did not dislocate his shoulder in this accident. He again injured his right shoulder when he fell while playing basketball. He cannot recall how he fell. He cannot recall if he dislocated his shoulder as a result of that fall. Following the basketball accident, he saw Dr. Tanveer before he saw Dr. Hilton. He told both doctors how the accident occurred. He did not tell Dr. Hilton he had previously dislocated his shoulder. He has no recollection of his shoulder popping in and out. He has no recollection of completing paperwork at Dr. Hilton's office. He has no recollection of telling Dr. DiLella of two interim dislocations. He cannot remember if he told Dr. DiLella he lifted a box overhead. He did tell Dr. Newman he lifted a box overhead. He resumed full duty as a stocker after his shoulder surgery. He continued performing full duty until his employment by Respondent came to an end. He currently drives a truck within a 250-

mile radius of his home. He is not required to perform any lifting. He drops trailers. He experiences right shoulder soreness and stiffness with extended sitting and on waking.

In addition to the exhibits previously summarized, Respondent offered into evidence print-outs of group payments made to Petitioner and his providers. The medical print-out (RX 5) contains some charges relating to treatment predating the claimed work accident. This print-out reflects that Petitioner incurred bills from both Dr. Tanveer and Dr. Hilton for services performed on June 21, 2010.

Arbitrator's Credibility Assessment

The Arbitrator had problems with Petitioner, credibility-wise.

Petitioner was able to recall the details of his claimed work accident but had some difficulty recalling the specifics of his other acknowledged shoulder injuries. Petitioner testified the work accident occurred while he was lifting a box onto a shelf that was slightly over his head. None of the records reflect that he was lifting overhead.

Petitioner testified he did not recall whether he dislocated his shoulder while playing basketball in June of 2010 but the forms he completed in connection with that incident clearly reflect that his shoulder "popped" out of and then back into place.

Petitioner initially denied injuring his shoulder at any point between the June 2010 basketball incident and his claimed work accident. Eventually, however, Petitioner acknowledged that such an injury might have occurred.

Petitioner did not offer into evidence records that might have helped the Arbitrator sort out the complicated causation issues presented herein. It is apparent that Petitioner saw his family physician, Dr. Tanveer, on June 21, 2010 and shortly after his claimed accident of December 7, 2010 but he did not offer this doctor's records into evidence.

Did Petitioner sustain an accident on December 7, 2010 arising out of and in the course of his employment?

Petitioner testified he felt a sharp onset of pain in his right shoulder while lifting a box slightly overhead on December 7, 2010. Petitioner testified he was working inside a cooler at that time. He felt the onset of pain with the third box. He indicated each box weighed between 50 and 80 pounds.

No one contradicted Petitioner's testimony as to his stocking duties. Petitioner testified he promptly notified his supervisor of the accident and spent the rest of his shift performing sweeping. Notice is not in dispute. The records reflect that Petitioner injured his shoulder while lifting boxes, although no overhead reaching is described.

Petitioner described an incident that occurred while he was performing his regular duties at his workplace during his shift. The Arbitrator finds that Petitioner established he sustained an accident on December 7, 2010 arising out of and in the course of his employment.

Did Petitioner establish a causal connection between the accident of December 7, 2010 and his current right shoulder condition of ill-being?

The Arbitrator finds that Petitioner failed to meet his burden of proof on the issue of causation. The records in evidence reflect that Petitioner dislocated his right shoulder at least once during the six months preceding the December 7, 2010 work incident, although Petitioner took issue with the histories recorded by Dr. Hilton. The records also document an earlier dislocation. Petitioner attempted to rely on his surgeon, Dr. DiLella, to establish causation but the "best" the doctor could say on this topic is that the December 7, 2010 incident could "possibly" have caused Petitioner's right shoulder to re-dislocate. He found it unlikely for a shoulder dislocation to not result in a labral tear, especially in a young patient such as Petitioner. Because his partner, Dr. Hilton, erred in failing to obtain an MRI following the basketball incident, there was "no way" for him to know exactly when Petitioner's labral tear occurred.

A claimant seeking benefits under the Act has the burden of proving all the elements of his case, including causal connection. The courts have held that this burden "must be met by a preponderance or greater weight of the evidence." Liability cannot be premised upon imagination, speculation or conjecture. A.M.T.C. of Illinois, Inc. v. Industrial Commission, 77 Ill.2d 482, 488 (1979).

Dr. DiLella resisted answering several of the causation-related questions posed on direct examination, indicating he would have to guess at an answer in the absence of serial MRI scans. This was at a point when he assumed a total of two shoulder dislocations. After Respondent's counsel showed him records referencing other dislocations, he became even more cautious. On redirect, he began using phrases such as "I suppose it's possible." It would be error for the Arbitrator to impose liability based on such equivocal testimony.

Having found that Petitioner failed to establish causal connection, the Arbitrator views the remaining disputed issues as moot. The Arbitrator makes no findings as to those issues.

Compensation is denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Steve Wicker,

Petitioner,

15IWCC0002

vs.

NO: 07WC38963

USF Holland,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) and 8(a) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issue(s) of medical expenses, temporary disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 11, 2014, 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.

15IWCC0002

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 $21,900.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JAN 5 - 2015
o12/17/14
RWW/rm
046

Ruth W. White

Charles J. DeVriendt

Daniel R. Donohoo

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

15IWCC0002

WICKER, STEVE
Employee/Petitioner

Case# **07WC038963**

USF HOLLAND
Employer/Respondent

On 4/11/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% 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:

0926 LEONARD LAW GROUP LLC
JOSEPH LEONARD ESQ
300 S ASHLAND AVE SUITE 101
CHICAGO, IL 60607

0766 HENNESSY & ROACH PC
EDWARD L HENNESSY
140 S DEARBORN 7TH FL
CHICAGO, IL 60603

15IWCC0002

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) & 8(a)

Steve Wicker
Employee/Petitioner

v.

USF Holland
Employer/Respondent

Case # 07 WC 38963

Consolidated cases: N/A

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Barbara N. Flores**, Arbitrator of the Commission, in the city of **New Lenox**, on **November 19 and 25, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **June 15, 2007**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$58,507.80**; the average weekly wage was **$1,125.15**.

On the date of accident, Petitioner was **43** years of age, ***married*** with **1** dependent child.

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

Respondent shall be given a credit for **all TTD/TPD paid through 4/30/13**, **$0** for maintenance, and **$0** for other benefits.

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

ORDER

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $750.10/week for 29 weeks, commencing May 1, 2013 through November 19, 2013 as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from June 15, 2007 through November 19, 2013, and shall pay the remainder of the award, if any, in weekly payments.

Prospective Medical Treatment

As explained in the Arbitration Decision Addendum, the Arbitrator awards the prospective right hip surgery and treatment recommended by Dr. Domb and Dr. Sporer pursuant to Section 8(a) of the Act.

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

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

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

Signature of Arbitrator

April 10, 2014
Date

ICArbDec19(b) p.2

APR 11 2014

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION *ADDENDUM*
19(b) & 8(a)

Steve Wicker
Employee/Petitioner

v.

USF Holland
Employer/Respondent

Case # **07** WC **38963**

Consolidated cases: **N/A**

FINDINGS OF FACT

Procedural History & Issues in Dispute

Petitioner initially filed a motion pursuant to Section 19(b-1) of the Act on September 17, 2013. Respondent filed its response along with a motion to strike on September 26, 2013. Pursuant to the rules, a pre-hearing conference was held on October 7, 2013 at which time the issues in dispute were not resolved informally. At that time, the depositions of two physicians had not yet been completed. Petitioner withdrew the Section 19(b-1) motion and the matter was set for a firm hearing date after the conclusion of the remaining depositions.

As reflected in the parties' Request for Hearing form, the issues in dispute include causal connection with regard to the right hip as a result of Petitioner's accident at work on June 15, 2007, Petitioner's entitlement to temporary total disability benefits commencing on May 1, 2013 through November 19, 2013, and whether Petitioner is entitled to prospective medical care as recommended by Dr. Domb with regard to Petitioner's right hip. Arbitrator's Exhibit[1] ("AX") 1; November 19, 2013 Arbitration Hearing Transcript at 4-9. The parties do not dispute that Petitioner sustained an accident at work on June 15, 2007 or causal connection with regard to Petitioner's low back through the date of this hearing. *Id.* Additionally, the parties did not raise the issue of Petitioner's entitlement to maintenance benefits at this hearing; they specifically indicated their reservation of rights to pursue or defend against such a claim related to either Petitioner's back or right hip condition at a future hearing if necessary. *Id.*

Background

At the hearing, Petitioner amended his original Application for Adjustment of Claim which reported an injury to the lower back, *instanter*, to reflect his claim that he injured his lower back and right hip. PX1; RX1.

Petitioner testified he worked for Respondent for 13 years as a truck driver prior to June 15, 2007. Tr. at 21. Petitioner performed the same job activities throughout this period of time including driving and anywhere between 15 and 25 freight pick-ups/deliveries depending on the daily workload. Tr. at 22-23. Petitioner testified that he did not miss work or have any medical treatment to his low back or right hip before June 15, 2007. Tr. at 21-22.

[1] The Arbitrator similarly references the parties' exhibits herein. Petitioner's exhibits are denominated "PX" and Respondent's exhibits are denominated "RX" with a corresponding number as identified by each party. Joint exhibits are denominated "JX." Exhibits attached to depositions will be further denominated with "(Deponent's Last Name) Dep. Exh. _." The November 19, 2013 Arbitration Hearing Transcript is denominated as "Tr." at the corresponding page numbers.

Petitioner testified that on June 15, 2007 he was dropping a hook on a trailer around two o'clock in the afternoon and attempted to get out of the truck when he was injured. Tr. at 24. He testified that it was typical for him to grab the steering wheel, door and climbing bar and slide his right side out and back out of the cab of the truck. Tr. at 24-25. He testified that when he stood he felt something in his back. *Id.* He described holding the steering wheel with his left hand and the climbing bar on the outside of the tractor with his right hand to descend from the truck. Tr. at 25-26.

Petitioner testified that he is a big guy and the cab of the truck is not as large as he would like so it is an awkward situation because he has to twist to turn to get out of the cab of the truck and he felt something like a pop or twinge or something in his back when he stood. Tr. at 26-27. He testified that he then climbed down and by the time he dropped and hooked the trailer 10-15 minutes later he could not move. Tr. at 27. Petitioner testified that he then pulled out into the street and sat there for about 40 minutes with pain in his lower back that radiated to his right side hip and down his thigh. Tr. at 27-28. He then pulled the truck in front of the terminal, went inside, and went to the clinic from there. *Id.*

Medical Treatment
Clearing Clinic & MacNeal Physical Therapy

The medical records reflect that Petitioner went to the Clearing Clinic on June 15, 2007 and saw Dr. Anatoly Gorovits at which time he reported that he sustained an injury while "[e]xiting truck, I got up and turned to grab on and climb down. I felt something in my lower back." PX2 at 25-26; RX11; RX17 at 1-2; Tr. at 29-30. He complained of back pain at a level of 10 out of 10 ("10/10"). *Id.* X-rays of the lumbar spine showed mild spondylosis. *Id.* Petitioner was prescribed medications and given restrictions. *Id.*

Petitioner presented for reevaluation three days later on June 18, 2007 and saw Dr. Anita Shah. PX2 at 21-24; RX17 at 3-6; Tr. at 30-31. He reported pain at a level of 8/10, but worse in the lower right back and radiating into the right buttock and sometimes into the groin area. *Id.* On examination, Petitioner had a positive straight leg raise on the right with pain in the lower back and he was unable to perform extension or side-to-side motion without pain. *Id.* Dr. Shah assessed Petitioner's condition as acute lumbar strain with some mild radiculopathy on the right, prescribed physical therapy, and imposed work restrictions. *Id.*

Petitioner then began physical therapy at McNeal Occupational Health Services. PX2 at 20; RX15 at 371-376; Tr. at 30. On a physical therapy patient questionnaire, Petitioner wrote that his primary injury was to his lower back and that the pain had spread "hip (right)[.]" *Id.* At his initial evaluation on June 19, 2007, the physical therapist noted "was getting out of truck + felt [pain] in back[, and pain] down [right] LE which has subsided[,]" and that Petitioner had muscle spasm of the right piriformis. PX2 at 16; RX17 at 7-9.

Petitioner was seen in physical therapy on June 21, 2007 reporting "some pain in the low back and hip." PX2 at 15; RX17 at 10. He continued in physical therapy and was discharged on July 6, 2007. PX2 at 8; RX17 at 11-17.

Petitioner returned to the Clearing Clinic on July 16, 2007 reporting pain at a level of 10/10 and some mild numbness in his right foot. PX2 at 7. He was provided medication and Dr. Shah recommended a lumbar MRI if symptoms persisted. *Id.* At the July 19, 2007 follow-up appointment, Petitioner expressed worsening symptoms of numbness down the right leg all way down to his foot that stayed numb all the time. PX2 at 5. Petitioner was diagnosed with a lumbar strain with right-sided radiculopathy, restricted to light duty work, given more Naprosyn and Vicodin for pain, and a lumbar MRI was ordered to rule out a herniated disc. *Id.*

Petitioner underwent the recommended lumbar MRI on July 27, 2007, which the interpreting radiologist noted showed a central and right paramedian disk herniation at L4-5 and moderate stenosis at other levels. PX2 at 4; RX17 at 19-20; Tr. at 31. He cancelled a scheduled physical therapy appointment at McNeal on July 24, 2007 and again indicated that he was going to see his own physician. PX2 at 6; RX17 at 18.

Hinsdale Orthopedics – Dr. Lorenz (Lumbar)

Petitioner then sought treatment with Dr. Mark Lorenz at Hinsdale Orthopedics on July 30 and 31, 2007. PX3 at 3-5, 12-13; RX15 at 370; RX16; RX17 at 21-27; Tr. at 31-35. He filled out a Patient Assessment form stating that his pain was at a level of 8/10, that it had been ongoing since the accident, and that he had "numbness in my right foot and pain in the right hip + leg." *Id.* On examination, Petitioner had a positive straight leg raise test bilaterally, difficulty with forward bending and extension, and a weak anterior tib on the right compared to the left. *Id.* After reviewing Petitioner's lumbar MRI, Dr. Lorenz recommended a Medrol Dosepak, physical therapy and possibly an epidural steroid injection. *Id.* He diagnosed Petitioner with an extruded disk herniation secondarily to the movement as described of getting out of the cab of his truck from a pre-stressed disc. *Id.*

Petitioner began physical therapy at ATI Physical Therapy on July 31, 2007. PX7 at 10-12. An initial Lumbar Evaluation was performed at ATI on August 1, 2007 at which time Petitioner's primary complaints were a "pinch in low back [right] hip pain, [right] side of calf, + [right] toes feel numb, [illegible] on [right]." PX7 at 24-27; RX15 at 366-369; RX17 at 28-31. Petitioner reported only minimal improvement in low back and hip pain at physical therapy as of August 6, 2007. PX7 at 29.

On August 7, 2007, Petitioner saw Dr. Lorenz who noted that he completed his Medrol Dosepak with minimal improvement and continued pain and numbness. RX17 at 36-37; Tr. at 36. He referred Petitioner to Dr. Bardfield for an epidural steroid injection. *Id.*

Petitioner returned to Dr. Lorenz on August 11, 2007 and completed a pain drawing wherein he identified pain in the low back and in the right hip and buttocks area. PX3 at 17-18. On August 24, 2007, Petitioner reported to his physical therapist that his right hip felt better. PX7 at 35.

Petitioner then underwent the recommended right L5 ESI with Dr. Bardfield on August 28, 2007 without improvement. PX3 at 24-28; PX5 at 5-22; RX17 at 43-44; Tr. at 36. Dr. Lorenz noted that conservative measures failed and recommended a right L4-L5 diskectomy. *Id.*

At physical therapy on September 6, 2007, Petitioner reported a burning sensation into his right hip region. PX7 at 38.

On September 18, 2007, Petitioner completed a pain drawing for Dr. Lorenz which identified aching, burning and stabbing type pain in the right hip and buttocks area. PX3 at 29-30; Tr. at 36-38. Dr. Lorenz noted that Petitioner returned after the epidural steroid injection, which did not help, and that he had continued weakness in the right leg and ankle. RX17 at 54. He recommended a diskectomy at L4-L5 right side. *Id.*

In a physical therapy note dated September 21, 2007, he reported that his right hip felt better. PX7 at 41. By his physical therapy visit of October 8, 2007, the physical therapist noted that Petitioner had palpable piriformis restrictions that failed to improve with stimulation. PX7 at 46.

Petitioner testified that while he participated in physical therapy at ATI, before undergoing his first lumbar surgery, he felt constant pain in the groin and lower back. Tr. at 72-74. He explained that he did exercises on a treadmill, elliptical machine or bicycle along with stretching and calisthenics. *Id.*

Respondent's First Section 12 Examination (Lumbar) – Dr. Bernstein

On October 15, 2007, Petitioner was examined by Dr. Avi Bernstein at Respondent's request. PX8 at 2-7; RX12; RX17 at 64-68; Tr. at 63-67. On this date, Petitioner filled out a patient information form indicating that his chief complaint was "lower back pain with hip + leg" as well as a patient history questionnaire noting that he had constant and radiating pain in the "lower back, hip, leg, ankle[.]" *Id.* Petitioner also completed a pain drawing—similar to the ones completed at Hinsdale Orthopedics—indicating that he had stabbing pain in the low back and burning pain in the right buttocks/hip area, the outside right part of the right calf, and the right ankle. *Id.*

Petitioner provided a history in which he denied any prior low back pain and progressively worsening symptoms. *Id.* He also "complains of pain across the low back, radiating down his right hip into his calf and ankle." *Id.* On examination, Dr. Bernstein noted that Petitioner walked with a slight right-sided antalgic gait and had a slight foot drop on the right side. *Id.* He noted weakness of the right EHL and slight weakness of the right foot dorsiflexion. *Id.* After reviewing Petitioner's lumbar MRI, which he noted showed lumbar spondylosis and a clear cut right sided L4-5 herniated disc, he opined that the injury resulted in a lumbar disc herniation and agreed with Dr. Lorenz's recommendation to proceed with surgery. *Id.*

First Lumbar Surgery & ATI Physical Therapy

On October 30, 2007, Petitioner returned to Dr. Lorenz reporting low back pain from 7-8/10 and pain that radiated into his buttock and into his right groin and thigh from 5/10 to 10/10. PX3 at 35-38; RX17 at 73-74; Tr. at 38-40. He filled out a pain drawing at this visit reporting a stabbing and burning pain in the right groin and hip area. *Id.*

Petitioner had physical therapy at ATI Physical Therapy through October 31, 2007. PX7 at 10-12; RX15 at 303-365.

Petitioner was admitted to Hinsdale Hospital and evaluated by Dr. Stanley Fronczak on November 2, 2007. RX17 at 78-79. Dr. Fronczak noted Petitioner's report of a "work-related injury while working for USF Holland on June 15, 2007. The patient apparently injured himself while exiting his vehicle. He complained of low back pain, which tends to radiate into the right posterior buttock and thigh, as well as some radiation into the groin and anterior thigh." *Id.* Petitioner was also evaluated by Dr. Lorenz pre-operatively who noted that Petitioner "gives a history of injuring himself while working as a truck driver for USF Holland, June 15, 2007, when he was getting out of his truck. He complained of low back pain, which is 7 to 8, radiates into his right buttock and into his right groin and right anterior thigh." RX17 at 80-81. Both physicians recommended surgery. RX17 at 78-81.

Petitioner underwent his first lumbar surgery on November 2, 2007 at Hinsdale Hospital. PX3 at 40-41; PX4 at 1-2; RX17 at 82-85; Tr. at 40-41. Post-operatively, Dr. Lorenz diagnosed Petitioner with an extruded disk herniation with radiculopathy on the right side at L4-5. *Id.* He performed a diskectomy at L4-5, right side, with foraminotomy and L5 root decompression. *Id.*

Petitioner followed up with Dr. Lorenz post-operatively on November 13, 2007 reporting no leg pain, just back pain. PX3 at 47-51; RX17 at 86-87. He filled out a pain drawing at this visit reporting stabbing pain in the low back. *Id.*

On November 27, 2007, Dr. Lorenz noted that Petitioner was feeling well overall but with some discomfort in the lower back and lateral femoral cutaneous nerve. PX3 at 53-54, 57-58; RX17 at 91-92; Tr. at 41-42. Petitioner filled out another pain drawing that indicated stabbing pain in the right groin and thigh area as well as in the low back. *Id.*

Dr. Lorenz ordered physical therapy which Petitioner had at ATI beginning December 3, 2007 through April 11, 2008. PX7 at 54-55; RX15 at 224-302; Tr. at 74. Petitioner testified that while he participated in physical therapy during this period engaged in the same type of physical activities that he did before his surgery, his lower back always hurt, and his groin pain continued to grow. Tr. at 74-75.

Petitioner underwent another Lumbar Evaluation at ATI on December 3, 2007. PX7 at 63-66. At this time, Petitioner's primary complaint was that his "[right] ankle feels weak, pain across low back, + still some pn around [right] hip + into groin, esp. [with] prolonged activity/mvmt[.]" *Id.* He also reported constant right hip pain that worsened with exercise. *Id.* Under significant findings in the Assessment Summary, the therapist noted radicular symptoms into Petitioner's right hip and a positive FABRE sign on the right hip. *Id.*

Physical therapy began on December 5, 2007 at which time Petitioner reported that his "[right] hip really hurts" and that he had right radicular symptoms to the hip and groin. PX7 at 67. On December 24, 2007, he reported that "my [right] hip/thigh is killing me today[.]" PX7 at 71. On December 28, 2007, Petitioner continued to report right hip pain that wrapped from back to front. PX7 at 72. On January 4, 2008, Petitioner reported that "my hip is getting better, but my back is really sore today[.]" PX7 at 74. On January 11, 2008, Petitioner reported to the physical therapist that, "[m]y back is still sore, no ankle [symptoms], less back intensity, [right] hip [symptoms] are knife like[.]" PX7 at 75. In a progress report dated January 14, 2008, the physical therapist noted Petitioner's report that his low back was feeling better, but that he was still concerned about his "[right] hip pain that has not improved since surgery." PX7 at 76. By January 16, 2008, Petitioner reported that his right hip "still really hurts" and his frustration with ongoing right hip symptoms. PX7 at 78. In the therapy notes from January 21, 2008 through January 30, 2008, Petitioner reported waxing and waning right hip symptoms. PX7 at 79-81. He mentioned to a physical therapist on February 5, 2008 that the "IME wants me to get an MRI on my hip[.]" PX7 at 83.

Petitioner returned to Dr. Lorenz on January 22, 2008 at which time he filled out a pain drawing at noting an aching pain in the low back and stabbing pain in the right groin and right hip area. PX3 at 59-65; RX17 at 110-112; Tr. at 42-44. On examination, Dr. Lorenz noted that Petitioner's right leg pain resolved with the surgery, but that his right groin pain had returned. *Id.* Petitioner also reported some right-sided back pain and buttock pain which he had prior to surgery. *Id.* Petitioner also reported that "[c]ertain activities such as lunges and squatting and things that involve the hips aggravate it." *Id.* Petitioner underwent x-rays of the pelvis, which showed normal age related changes of both hip joints with no signs of significant arthritis. *Id.*

Respondent's Second Section 12 Examination (Lumbar) – Dr. Bernstein

Petitioner returned to Dr. Bernstein at Respondent's request on February 4, 2008. PX8 at 8-13; RX12; RX17 at 114-116; Tr. at 67-70. Petitioner filled out a second patient information form indicating that his chief complaint was "post surgery still lower back pain and hip[.]" *Id.* He also completed another patient history questionnaire

noting that he had constant and radiating pain in the "lower back, groin, hip[.]" *Id.* Petitioner also completed a pain drawing indicating that he had stabbing pain in the low back and in the right groin area, burning pain in the right buttocks/hip area, and numbness in the right front thigh area. *Id.*

Dr. Bernstein noted that Petitioner's sciatic complaints had improved, "[h]e does, however, continue to complain of low back pain and pain into the right buttock and also into his groin." *Id.* On examination, Dr. Bernstein noted that manipulation of the right hip "causes acute groin pain, particularly with internal rotation." *Id.* Pelvic x-rays also demonstrated joint space narrowing suggesting hip arthritis. *Id.*

Dr. Bernstein indicated that Petitioner had some residual discogenic symptoms related to the low back and "sensitivity of his right hip and some of his complaints may be related to right hip osteoarthritis." Dr. Bernstein recommended a pelvic MRI to clarify this. *Id.*

Petitioner testified he was not sure whether the pelvic MRI recommendation was ever submitted for approval. Tr. at 90-91. He also testified that he continued to treat with Dr. Lorenz and, other than the pelvic x-ray, he did not have any treatment or testing referral to the right hip. Tr. at 91-92.

Continued Medical Treatment & First Functional Capacity Assessment

At physical therapy on February 11, 2008, Petitioner reported that "his R hip pain is much better since treatment modified to address numerous mm restrictions around R hip." PX7 at 85. Additional physical therapy was recommended. *Id.* Petitioner had physical therapy/work conditioning from February 18, 2008 through February 22, 2008 during which time the physical therapist noted Petitioner's subjective reports of increased right hip and low back pain. PX7 at 113. Specifically, Petitioner reported that his "hip has been achy and uncomfortable this whole week and I returned to work with modified duties." *Id.*

On February 26, 2008, Dr. Lorenz ordered a repeat MRI to rule out a recurrent disk herniation. PX3 at 67-72; RX17 at 122; Tr. at 44-46. Petitioner filled out a pain drawing reporting stabbing pain in the low back and right knee, and burning pain in the right buttock area. *Id.*

On February 28, 2008, Petitioner underwent the recommended repeat lumbar MRI which the interpreting radiologist noted showed post-operative changes at L4-L5 with moderate central spinal stenosis and moderate bilateral foraminal stenosis, stable moderate bilateral foraminal stenosis at L5-S1, and a small central disk protrusion with moderate-to-severe central spinal stenosis and mild-to-moderate bilateral foraminal stenosis at L2-L3 and L3-L4. PX3 at 75-78; RX17 at 130-133. Petitioner saw Dr. Lorenz and his certified physician's assistant, T. Lindlay Pittman, the same day at which time a right transforaminal epidural steroid injection at L4-L5 was recommended. PX3 at 75-78; RX17 at 129. Dr. Lorenz also put Petitioner's work hardening program on hold to perform further diagnostic testing to address Petitioner's continued low back pain and right hip pain. PX7 at 115.

Petitioner had the recommended injection with Dr. Bardfield on March 18, 2008. PX3 at 80; PX5 at 23-43; RX17 at 138-139.

On April 9, 2008, Petitioner returned to Dr. Lorenz reporting continued back and right buttock pain. PX3 at 82-85. Dr. Lorenz recommended another epidural steroid injection, which Petitioner underwent with Dr. Bardfield on April 15, 2008. PX3 at 86; PX5 at 44-59; RX17 at 147-148, 150-151.

Petitioner returned to work conditioning at ATI on April 16, 2008 after having additional work-up and injection to the lumbar area. PX7 at 123. The physical therapist noted "[c]onservative increases in weight with squatting activities have been noted, however pain through the back and hip continue." PX7 at 133. He continued in physical therapy through May 9, 2008. RX15 at 212-221. For the period of May 5, 2008 through May 9, 2008, the physical therapist noted Petitioner's report of "a significant decrease in low back and right hip pain...." PX7 at 154; RX15 at 212.

On May 19, 2008, Petitioner underwent a functional capacity assessment at ATI at which time Petitioner demonstrated functional capabilities at the medium-heavy physical demand level. PX7 at 156-163; RX17 at 165-172; Tr. at 76. The test results were deemed valid. *Id.*

On May 22, 2008, Petitioner returned to Dr. Lorenz reporting significant back and right leg pain. PX3 at 93-97; RX17 at 173; Tr. at 46. His pain drawing of the same date indicates stabbing pain in the low back and right knee as well as burning pain in the right buttock. *Id.* Dr. Lorenz ordered a myelogram and diskogram. *Id.*

Petitioner underwent the myelogram on May 30, 2008, which the interpreting radiologist noted showed multilevel degenerative changes at the lumbar spine, multilevel central canal narrowing most pronounced at L1-2, L2-3, and L3-4, and bilateral neural foraminal narrowing most pronounced at L4-5 and L5-S1 with bilateral findings of moderate-to-severe disease. PX3 at 99-101; RX17 at 174-181; Tr. at 46.

On June 4, 2008, Petitioner saw Dr. Lorenz reporting aching pain across the low back and into the right buttock area. PX3 at 102-105; RX17 at 182. He also completed a pain drawing indicating stabbing pain in the low back and burning pain in the right buttock area. *Id.*

Dr. Lorenz performed the diskogram on June 10, 2008 and he found concordant and identical pain at the levels of L4-L5 and L5-S1 with his usual low back and right-side pain. PX3 at 106-108; PX5 at 60-78; RX17 at 183-189; Tr. at 47. At L1-2, L2-3, and L3-4, Dr. Lorenz found low-to-moderate pain which was non-concordant and different than his usual pain. *Id.*

At a follow up visit on June 24, 2008, Petitioner reported ongoing low back and right leg pain. PX3 at 109-110; RX17 at 191-192; Tr. at 47. His pain drawing indicates stabbing pain in the low back and burning pain in the right hip. *Id.* An additional surgery was discussed and Petitioner was to return in one month to determine further treatment. *Id.*

Petitioner initially declined any additional surgery on July 24, 2008 and Dr. Lorenz indicated that he would return on an as-needed basis. PX3 at 117; RX17 at 195.

Respondent's Third Section 12 Examination (Lumbar) – Dr. Bernstein

Petitioner returned to Dr. Bernstein a third time at Respondent's request on August 7, 2008. PX8 at 14-18; RX12; RX17 at 196-199 Tr. at 70-72. He again filled out a patient information form indicating that his chief complaint was "back pain lower/right hip[.]" *Id.* He also completed another patient history questionnaire noting that his problem was "lumbar and right hip pain" and that he had constant and radiating pain in the "back/hip[.]" *Id.* Petitioner also completed a pain drawing indicating that he had stabbing pain in the low back and burning pain in the right buttocks/hip area. *Id.*

Dr. Bernstein noted that a recent diskogram demonstrated concordant pain at L4-L5 and L5-S1. *Id.* He also

examined Petitioner noting that he walked without an antalgic gait, but that he forward flexed to protect his low back and had reversal of rhythm. *Id.* Dr. Bernstein opined that Dr. Lorenz's recommendation for spinal fusion at L4-L5 and L5-S1 was appropriate although he also indicated a hybrid procedure including a fusion and disc replacement may be considered. *Id.*

Second Lumbar Surgery & ATI Physical Therapy

Petitioner returned to Dr. Lorenz on September 3, 2008 reporting back pain and pain radiating down his right leg. PX3 at 119-123; RX17 at 200, 205; Tr. at 48-49. His pain drawing indicates stabbing pain in the low back, burning pain in the right buttocks, and aching pain in the right knee and ankle. *Id.* Petitioner indicated that he wanted to undergo the recommended surgery. *Id.*

Petitioner was admitted to Hinsdale Hospital on September 12, 2008 to undergo a second surgery with Dr. Lorenz and Dr. Fronczak. PX3 at 124-125; PX4 at 3-9; RX17 at 215-225. Pre- and post-operatively, Dr. Lorenz diagnosed with the following: (1) L2-L3 bilateral stenosis; (2) L3-L4 bilateral gutter stenosis; (3) recurrent disk herniation, L4-L5 central; (4) right-sided L5-S1 disk herniation; (5) segmental instability, L4-L5 and L5-S1; (6) morbid obesity BMI greater than 37; and (7) status post L4-L5 diskectomy. PX3 at 126-129; RX17 at 222-226. Dr. Lorenz performed bilateral decompressive laminectomies at L2-L3 and L3-L4 as well as a two-level posterior spinal fusion from L4-S1. *Id.*

On September 24, 2008, Petitioner saw Dr. Lorenz post-operatively reporting no sharp stabbing pain in the back like before surgery, no shooting pain in the groin or thighs, no radiculopathy, but some residual numbness in the right foot. PX3 at 141-147; RX17 at 244-246.

On October 2, 2008, Petitioner indicated aching pain in the low back and pins-and-needles sensation in the right foot as well as some drainage from the surgical wound. PX3 at 148-151; RX17 at248-249; Tr. at 48. He was readmitted to the hospital by Dr. Lorenz for surgical wound incision and drainage the following day on October 3, 2008 and discharged from the hospital on October 7, 2008. PX3 at 152-154; PX4 at 15; RX17 at 251, 259-260.

At a follow up visit on October 27, 2008, Petitioner indicated aching pain in the low back and difficulty sleeping, but was otherwise improving. PX3 at 155-161; RX17 at 264-265. Petitioner was directed to continue seeing Dr. Sherman for antibiotics, continue use of the LSO brace, and to return in one month for re-evaluation. *Id.* On November 17, 2008, a nurse at Hinsdale Orthopedics noted that Petitioner was being referred to a pain clinic for evaluation of his pain medication regimen and for further pain treatment. PX3 at 161-162; RX17 at 266.

Dr. Lorenz saw Petitioner again on December 1, 2008 at which time he complaining of pain in the right groin and a little bit of pain in the groin with internal and external rotation of the right hip. PX3 at 163-170; RX15 at 207-209; RX17 at 267-269; Tr. at 49-50. Petitioner completed another pain drawing indicating aching pain in the low back and buttocks and a stabbing pain in the right groin and hip area. *Id.* He was given a referral for physical therapy and again told to follow up with the pain clinic. *Id.*

Petitioner returned to physical therapy at ATI from December 4, 2008 through March 4, 2009. PX7 at 168-170; RX15 at 130-194; Tr. at 75. He underwent another Lumbar Evaluation on December 4, 2008 at which time he reported a primary complaint of "LBP, [decreased right] front of hip pain (groin pn)...." PX7 at 180-183; RX15 at 195-206.

From Pain to Wellness – Dr. Gruft (Pain Management) & Continued Medical Treatment

Dr. Gruft first evaluated Petitioner on December 17, 2008. PX10 at 4-9; RX14 at 172-189; RX17 at 280-282; Tr. at 77. Petitioner reported that he was experiencing numbness in his hip and provided a history of pain in the lower back radiating to the right buttock area. *Id.* He also reported a history of pain was sharp and stabbing back pain, pulling in the iliotibial band area, and associated core body weakness and numbness in the hip area. *Id.* On examination, Dr. Gruft noted that Petitioner had a positive FABER sign referring pain to the right posterior superior iliac spine, and tenderness over the posterior superior iliac spine with hypomobility of the right SI joint. *Id.*

Petitioner continued to see Dr. Gruft at the pain center roughly once a month through December 7, 2009. PX10; PX11 at 4-21; Tr. at 77. He provided varying narcotic medications for pain control including Norco, Oxycontin, and Morphine during Petitioner's pain management in 2010, 2011, and 2012. *Id*; Tr. at 56. Petitioner reported primarily low back complaints during this period of time, but also reported right glute pain on April 2, 2009, right buttock and left hip pain on September 2, 2009 and left hip pain on September 17, 2009. RX14 at 51, 133.

A physical therapy note of December 19, 2008 reflects that Petitioner's "[right] hip flexor flexibility improved but still very weak; better [with] mult. Hip ex." PX7 at 188. A physical therapy progress report dated December 31, 2008 reflects the physical therapist's notation that Petitioner had improved right hip flexion after 13 visits. PX7 at 192. Another physical therapy progress report dated January 29, 2009 reflects Petitioner's report pain in his right hip pain was much better and that his hip felt more flexible. PX7 at 202.

Petitioner returned to Dr. Lorenz on January 29, 2009 at which time he reported back pain at a level of 3-4/10 that occasionally was at an 8/10. PX3 at 172-177; RX17 at 297-301; Tr. at 50. Petitioner had completed 25 physical therapy sessions at this point and that it was going fairly well. *Id.* In his pain drawing, Petitioner indicated aching pain in the low back, stabbing pain in the low back/buttocks, and some aching pain in the mid-back. *Id.* Dr. Lorenz indicated that Petitioner should continue seeing his pain management physician and continue with physical therapy to be followed by a functional capacity assessment. *Id.*

Petitioner was discharged from physical therapy on March 4, 2009 per Dr. Lorenz's orders for a functional capacity assessment. PX7 at 211; Tr. at 75.

Petitioner underwent the second functional capacity assessment at ATI on March 5, 2009. PX7 at 213-220; RX17 at 311-325; Tr. at 76. During the exam, Petitioner noted leg pain radiating through the right hip with lifting from 18 inches to floor and return. *Id.* He also noted stabbing pain in the right hip and radiating pain returning at 37 lbs. for right sided carrying. *Id.* Ultimately, Petitioner demonstrated functional capabilities at the medium physical demand level. *Id.* The test results were deemed valid. *Id.*

On March 9, 2009, Petitioner reported more right-sided low back pain ranging from 4-8/10 and tenderness over the right sacroiliac joint and the right piriformis on examination. PX3 at 178-182; RX17 at 326-331; Tr. at 50-51. His pain drawing indicated a stabbing pain in the right side of the low back and a burning pain in the right hip. *Id.* Dr. Lorenz noted that Petitioner completed a functional capacity assessment that was valid and placed him at the medium physical demand level. *Id.* Dr. Lorenz noted that Petitioner was unable to return to work at the heavy physical level. *Id.* Petitioner was again advised to continue with treatment with Dr. Gruft at the pain clinic and he was advised to return as needed. *Id.*

Petitioner returned for another short course of physical therapy at ATI on June 17, 2009 and underwent another Lumbar Evaluation. PX7 at 224-227; RX15 at 122-129; Tr. at 75. At that time, he reported pain above the incision area that went into his head and caused headaches. *Id.* Petitioner's pain reports were generalized to the low back. *Id.* He received additional therapy at ATI from June 19, 2009 through July 23, 2009. PX7 at 228-244; RX15 at 89-121; Tr. at 75.

Petitioner also continued to see Dr. Gruft for pain management from January 4, 2010 through December 23, 2010. PX11 at 21-106; Tr. at 56, 77.

On September 28, 2010, Dr. Gruft referred Petitioner back to Dr. Lorenz for examination of a wound and he was later evaluated by Dr. Lorenz and Dr. Fronczak. PX3 at 183-188; PX4 at 10-16; RX13 at 10-17; RX17 at 410-415, 422-423, 425-428; Tr. at 52-53. He was admitted by Dr. Lorenz to Hinsdale Hospital for a wound infection and underwent an incision and drainage procedure with Dr. Lorenz and Dr. Fronczak on October 1, 2010. *Id.* A second incision and drainage procedure was performed on October 5, 2010. PX3 at 188-189; PX4 at 11-12; RX17 at 429-432; Tr. at 54.

On October 21, 2010, Petitioner saw Dr. Fronczak after the hardware removal surgery and following the infection drainage procedures. RX13 at 9; RX17 at 439. He scheduled a follow up visit in two weeks to ensure that the wound was healing properly. *Id.* On November 4, 2010, Petitioner returned to Dr. Fronczak who noted that Petitioner was doing well and referred him back to Dr. Lorenz. RX13 at 8; RX17 at 446. On December 2, 2010, Dr. Fronczak indicated that Petitioner did not require additional neurosurgical follow up and referred him back to ATI for physical therapy. RX13 at 6-7; RX15 at 85-86; RX17 at 454.

Petitioner returned to ATI on December 7, 2010 for another Lumbar Evaluation. PX7 at 246-249; RX15 at 75-84.

Petitioner participated in therapy from December 9, 2010 through February 1, 2011. PX7 at 257-276; RX15 at 62-74; Tr. at 75-76.

Third Lumbar Surgery & Continued Medical Treatment

Petitioner was admitted to Hinsdale Hospital on December 28, 2010 for lumbar hardware removal and another wound incision and drainage procedure. PX3 at 190-192; Tr. at 53.

Dr. Lorenz then ordered a third functional capacity assessment on January 25, 2011. PX7 at 273. Petitioner underwent the assessment at ATI on February 3, 2011. PX7 at 277-284; PX9; RX17 at 481-488; Tr. at 53, 76. During the evaluation, Petitioner reported right-sided mid and low back and right leg weakness more than in the left leg. *Id.*

Petitioner returned to Mr. Pittman, Dr. Lorenz's physician's assistant, post-operatively on March 7, 2011 reporting increasing back pain at 5-7/10, pain again down the right leg, and some weeping from the interior part of the surgical incision. PX3 at 190-192; RX17 at 495-497; Tr. at 54. Petitioner's x-rays confirmed removal of the hardware. *Id.* Dr. Lorenz noted that Petitioner continued to have upper thoracic pain throughout the day. *Id.* He diagnosed Petitioner with an L4-S1 fusion, thoracic pain, status post wound incision and drainage, and a superficial wound. *Id.* Petitioner was referred to Dr. Gruft for continued pain management. *Id.* Dr. Lorenz ordered a repeat lumbar MRI as well as a thoracic MRI, which the interpreting radiologist noted showed mild spondylotic impressions upon the dural sac without focal disc herniation or significant stenosis. PX3 at 193-

194.

Petitioner also continued to see Dr. Gruft for pain management from January 4, 2011 through December 21, 2011. PX11 at 106-156; RX14 at 39-43; Tr. at 56, 78.

On March 21, 2011, Mr. Pittman, Dr. Lorenz's physician's assistant, examined Petitioner noting a negative straight leg raise test with trace weakness in hip flexion on the right which was five minus. PX3 at 195-196; RX17 at 516-521; Tr. at 54-55. Petitioner was diagnosed status post L4-S1 fusion, L2-L4 decompressive laminectomy, and I&D with hardware removal as well as with recurrent stenosis at L2-3 and L3-4 with severe stenosis at L1-2 and neurogenic claudication. *Id.* Petitioner was instructed to continue with pain management and referred to another physician for follow up on the thoracic spine complaints. *Id.*

Petitioner returned to Dr. Lorenz's physician's assistant on May 23, 2011 reporting continued back and right buttock pain. PX3 at 197-200; RX17 at 527.

Petitioner then switched to physical therapy at Speckman Rehab Center from June 8, 2011 to July 15, 2011 roughly 30 days. PX13; RX15 at 6-61. The Speckman records reflect that Petitioner reported low back pain as well as sciatic pain radiating down the right buttock and he noted burning pain in the right buttock area in his pain drawings. *Id.*

Petitioner testified that he switched providers because the therapy at ATI was aggressive. Tr. at 80. He added that he could not handle too much of the physical therapy at ATI, that it hurt too much and he was in too much pain in the lower back and right groin. Tr. at 80-81.

Several months later, on December 29, 2011, Dr. Lorenz ordered a repeat lumbar MRI. PX3 at 199. The following day, Petitioner was admitted to the emergency room at Hinsdale Hospital on December 30, 2011. PX4 at 17-18; RX17 at 604-605, 614-616; Tr. at 55. Petitioner reported swelling along his back scar with drainage. *Id.* The small drainage area was opened and further drained. *Id.* He was discharged home and instructed to follow up for his MRI. *Id.*

Petitioner underwent the recommended MRI on January 5, 2012 at which time the radiologist noted a history of "[i]nfection 12/25/2011. Pain across back into both hips." PX3 at 200-201; RX17 at 622-623; Tr. at 55. Petitioner reported having some drainage and going to the emergency room after which he saw Dr. Lorenz on January 12, 2012. PX3 at 202; RX17 at 624. Dr. Lorenz ordered some physical therapy and possibly a repeat functional capacity assessment on completion. *Id.*

Petitioner continued to see Dr. Gruft for pain management from January 18, 2012 through November 26, 2012. PX12 at 3-13; Tr. at 78. Petitioner reported primarily low back complaints, but also reported right hip complaints on May 21, 2012, June 18, 2012, July 16, 2012 and November 26, 2012. RX14 at 288, 296, 308.

On January 25, 2012, Petitioner reported "100% back pain" and Dr. Lorenz's physician's assistant noted pain on forward flexion and extension. PX3 at 203; RX17 at 626-627. He diagnosed Petitioner as status post L4-S1 fusion, lumbar decompressive laminectomy, lumbar hardware removal, and post-op superficial wound as well as with recurrent stenosis at L1 through L4. *Id.* Petitioner was going to begin physical therapy and continue to see Dr. Gruft for pain management. *Id.*

On March 26, 2012, Petitioner saw Dr. Lorenz's physician's assistant and reported increasing low back

symptoms and that standing upright caused more symptoms in the legs. PX3 at 204-206; RX17 at 632-633; Tr. at 55-56. He recommended a second lumbar myelogram. *Id.*

On May 16, 2012, Petitioner saw Mr. Pittman again and reported increasing symptoms with neurogenic claudication, difficulty lying flat at night, heaviness in his legs, pain radiating into his right groin and right thigh which improved with forward flexion and fatigue in the legs. PX3 at 209-210; RX17 at 645-646; Tr. at 55-56. The myelogram had not yet been approved. *Id.* On examination, forward flexion produced groin pain. *Id.* He was advised to continue pain management and to return after a myelogram. *Id.*

Respondent's Fourth Section 12 Examination (Lumbar) – Dr. Ghanayem

On May 16, 2012, Respondent sent an engagement letter to Dr. Alexander Ghanayem at Loyola University Medical Center requesting that he evaluate Petitioner. PX16 at 1-16; RX2. Petitioner submitted to this fourth independent medical evaluation at Respondent's request with Dr. Ghanayem on July 12, 2012. PX16 at 22-23.

Petitioner provided a history of the accident indicating that when he got out of the cab in his truck he experienced intense back and leg pain and difficulty moving within about 30 minutes of the incident. *Id.* On examination, Dr. Ghanayem noted that Petitioner had tenderness and tightness to palpation in the paraspinal musculature, lumbar range of motion to about 45 degrees of flexion and 10 degrees of extension, and much more painful extension than lumbar flexion. *Id.* He also noted that Petitioner had tension signs causing buttock pain bilaterally, more so on the right. *Id.* Dr. Ghanayem ultimately opined that Petitioner's lumbar disc herniation was both central and to the right, which was a competent cause of his back and right-sided leg pain. *Id.* He agreed that Petitioner was in need of another decompressive surgery, but did not recommend extending his fusion. *Id.*

On August 17, 2012, Respondent requested that Dr. Ghanayem opine on the propriety of a laminectomy from L1-L4, whether Petitioner required ongoing pain management, and if Petitioner declined to have additional surgery when he would be at maximum medical improvement. PX16 at 17-18; RX2. Dr. Ghanayem issued an addendum report dated August 23, 2012 in which he concurred with the recommended surgery, indicated that Petitioner's pain management was reasonable and that, hopefully, Petitioner could be weaned off of the narcotic pain medication after surgery. PX16 at 24.

Fourth Lumbar Surgery & Continued Medical Treatment

Dr. Lorenz's physician's assistant next examined Petitioner on August 22, 2012 at which time Petitioner complained of right buttock, thigh, and groin pain. PX3 at 211-212; RX17 at 649-650; Tr. at 55-56. On examination, Petitioner had mild pain noted on the right hip with internal rotation. *Id.* An L1-L4 laminectomy was recommended and Mr. Pittman noted that if Petitioner had "ongoing Hip pain postop this will be further worked up." *Id.*

Petitioner was admitted to Hinsdale Hospital on August 24, 2012. PX3 at 213-220; PX4 at 19-20; Tr. at 56. On admission, Petitioner complained of buttock pain on the right side radiating into the right thigh and groin with occasional numbness and buckling on the right. *Id.*

Pre- and post-operatively, Dr. Lorenz diagnosed Petitioner with L1-L2, L2-L3, and L3-L4 lumbar spinal stenosis and lumbar polyradiculopathy secondary to this diagnosis from L2-L4. PX3 at 221-222; RX17 at 655-660. He performed re-exploration of the previous lumbar laminectomy with extremely difficult dissection as a result of

previous surgical intervention, L2 and L3 decompressive lumbar laminectomy and a partial L1 laminectomy with bilateral L1-L3 nerve root decompression. *Id.* He was discharged on August 27, 2012. RX17 at 661-662.

Petitioner saw Dr. Lorenz's physician's assistant on October 4, 2012 at which time he reported mild low back pain, completely resolved leg pain had completely resolved, and some shooting pain into his right hip again with increased walking. PX3 at 224-228; RX17 at 676-677. Petitioner completed another pain drawing in which he indicated aching pain in the low back, burning pain in the right buttocks, and stabbing pain in the right hip and groin areas. *Id.* He was taking Norco and Morphine and, on examination Petitioner had full range of motion of both hips without pain. *Id.*

On November 7, 2012, Petitioner saw Mr. Pittman again and reported continued right hip pain, continued low back pain with activity, and still getting catching in his hip from time to time. PX3 at 229-235; RX8; Tr. at 56-59, 88-89. On examination, Petitioner had mild discomfort on internal and external rotation of the right hip and no pain on the left. *Id.* He completed another pain drawing indicating aching pain throughout the thoracic and low back, burning pain in the right buttocks, and stabbing pain in the right hip and groin. *Id.* Dr. Lorenz ordered an MRI of the right hip. *Id.*

Petitioner underwent the recommended right hip MRI on November 14, 2012 for "[c]hronic hip pain." PX3 at 236-238. The interpreting radiologist found extensive high grade chondromalacia along the articular surface of the acetabulum, an acetabular labral tear, very mild greater trochanteric bursitis, and high grade chondromalacia within the articular surface of the left acetabelum for which a dedicated left hip MRI might be considered. *Id.* A hip specialist evaluation was recommended on November 16, 2012 and, on November 26, 2012, Petitioner was referred to Dr. Domb. PX3 at 240-241; RX17 at 682-684; Tr. at 58.

Petitioner returned to Dr. Gruft's office on December 12, 2012 at which time Petitioner's "new [right] hip labral tear" was noted. RX14 at 277.

Fifth Section 12 Examination (Right Hip) – Dr. Ghanayem

On December 18, 2012, Respondent asked Dr. Ghanayem to opine whether Petitioner's hip issues were plausibly related to the back injury Petitioner sustained on June 15, 2007. PX16 at 19; RX2. Dr. Ghanayem was provided updated materials from Hinsdale Orthopedics to review. PX16 at 20-21. On January 7, 2013, Dr. Ghanayem examined Petitioner a second time. PX16 at 25-26.

Petitioner reported some residual pain in the right buttock, some groin pain and arthritis and a labral tear. *Id.* On examination, Dr. Ghanayem noted that Petitioner walked with a decreased stance on the right leg, Petitioner's report that when he walked he had groin pain on the right side, and groin pain with internal and external rotation of the right hip. *Id.*

Dr. Ghanayem opined that Petitioner had what appeared to be "new onset groin pain associated with the increased ability to walk[,]" and that it appeared that Petitioner's "increased ability to walk simply unmasked an underlying hip arthritis problem." *Id.* He specifically opined that Petitioner's right hip condition did not seem to be a hip injury from his work accident, it did not appear to be a problem with an abnormal gait causing a hip problem, and his right hip/groin condition was an unrelated medical issue. *Id.*

Petitioner testified that the examination was about five minutes long and that he did not do anything compared to what Dr. Sporer and Dr. Domb did during their examinations. Tr. at 81-82.

Continued Medical Treatment

Petitioner continued to see Dr. Gruft for pain management from January 7, 2013 through November 18, 2013. PX12 at 13-30; Tr. at 78. Petitioner reported low back and right hip complaints during this period of time. RX14 at 250, 252, 254, 256-268, 273, 275, 280, 282, 284, 286.

Petitioner then returned to Dr. Lorenz on January 16, 2013 reporting that some low back pain and continued difficulty with the right hip particularly when standing or ambulating. PX3 at 242-244; RX17 at 686-687. On examination, Dr. Lorenz noted that Petitioner had pain on internal and external rotation of the hips, and antalgic gait favoring the right hip, limited bending and extension due to some back and hip pain, and that he had not yet been seen for an evaluation by Dr. Domb. *Id.* He was again given a referral to see Dr. Domb to evaluate the right hip and instructed to continue seeing Dr. Gruft for pain management. *Id.*

Petitioner testified that he was not allowed to see Dr. Domb through the [workers' compensation] insurance company so he then saw Dr. Domb at his own attorney's request. Tr. at 59-60.

Petitioner's First Section 12 Examination (Right Hip) – Dr. Domb

On February 7, 2013, Petitioner saw Dr. Benjamin Domb at Hinsdale Orthopedics at Petitioner's counsel's request. PX6; RX19; Tr. at 60-61, 94. Petitioner provided a history in which he reported that he started noticing hip pain on June 18, 2007 that started in the groin and that his hip pain continued throughout physical therapy. *Id.* At the time of his examination, Petitioner reported significant right hip pain that had increased since August and was constant, sharp and stabbing in quality ranging in pain level from 7-8/10. *Id.* He also reported that his pain was aggravated by walking. *Id.* He experienced sharp stabbing pain at times and a feeling of buckling. *Id.* His pain was alleviated by lying down with pillows under his back and knees to keep his hip in a flexed position. *Id.*

Dr. Domb reviewed Petitioner's treating medical records including those from the Clearing Clinic, ATI, McNeal Rehab Center, Hinsdale Orthopedics, Hinsdale Hospital, and the MRI of the right hip. *Id.* He also reviewed Dr. Bernstein's reports. *Id.* Dr. Domb performed a physical examination of Petitioner and took x-rays of the pelvis comparing them to earlier x-rays from 2008. *Id.* On examination, Petitioner ambulated with a right antalgic gait, shortened stance and flexed right hip. *Id.* He had tenderness to palpation of 2+ over the iliopsoas and greater trochanter as well as tenderness at 1+ over the sacroiliac joint. *Id.* Petitioner had hip flexion to 90 degrees with pain, a 10 hip flexion contracture, 5 degrees of internal rotation, and 15 degrees of external rotation. *Id.* Petitioner also exhibited positive anterior impingement, positive log roll with internal and external rotation, positive FABER sign and 4/5 hip flexor strength. *Id.*

After reviewing Petitioner's diagnostic films, Dr. Domb noted that Petitioner noted severe hip pain a few days after his injury at work on June 15, 2007 and that he underwent extensive treatment of the low back such that he did not have his right hip addressed until an MRI in November of 2012. *Id.* Dr. Domb stated that Petitioner's injury at work "most likely caused a labral tear and/or cartilage damage back in 2007. Over the ensuing years, the labral tear and/or cartilage damage has led to progressive loss of the cartilage as a result. This has lead him to the current moment where he has fairly severe osteoarthritis of the right hip which is symptomatically incredible severe." *Id.*

Dr. Domb opined that Petitioner's right hip condition was caused by the work injury and remained symptomatic

ever since that time. *Id.* He recommended a minimally invasive robotic hip replacement. *Id.* He also noted that "[a]t no point have I solicited Mr. Wicker as a patient." *Id.*

Petitioner's Second Section 12 Examination (Right Hip) – Dr. Sporer

On April 11, 2013, Petitioner's counsel requested Dr. Scott Sporer at Midwest Orthopedics at Rush to evaluate Petitioner's right hip. PX14 at 1-3; PX15; Tr. at 62-63. Dr. Sporer did so on June 12, 2013. PX14 at 4-8; Tr. at 62-63, 92-93. On this date, Petitioner provided a history in which he reported that he was injured at work while climbing out of the cab of his truck and "that by the time he reached the ground, he began having thigh pain as well as groin pain." *Id.* He also reported that he had no prior back or hip pain before his accident. *Id.* At the time of this examination, Petitioner reported discomfort in his groin, posterior buttock pain down to the level of his knees, using a cane to walk due to a sensation that his hip was going to give out, and persistent pain and discomfort in the right hip. *Id.*

On examination, Dr. Sporer noted hip flexion to about 90 degrees with pain, a 10-15 degree hip flexion contracture, 5 degrees of internal rotation and 20 degrees of external rotation to the right hip with pain at extremes, positive anterior impingement test, positive straight leg raises with pain, 4/5 hip flexor strength, and mild discomfort to palpation over the greater trochanter. *Id.*

Dr. Sporer diagnosed Petitioner with right hip degenerative arthritis. *Id.* He opined that Petitioner's hip condition pre-existed his injury at work, but that it was aggravated by the work accident and there was a causal relationship between Petitioner's right hip condition at the June 15, 2007 accident. *Id.* Dr. Sporer based his opinion on Petitioner's lack of hip pain before his accident, ongoing symptoms in the groin despite multiple treatments to the low back, and groin symptoms that were described immediately after the injury and extensively documented in his treating medical records. *Id.* He recommended a total right hip arthroplasty. *Id.*

Deposition Testimony – Dr. Domb

On May 19, 2013, Petitioner called Dr. Domb as a witness at which time he provided testimony. PX20. He is a board-certified orthopedic surgeon with a hip specialization. PX20 at 6-11 & Domb Dep. Exh. 1.

Dr. Domb testified about his examination of Petitioner, review of medical records and diagnostic films, and the opinions about Petitioner's right hip condition contained in his reports. *See generally* PX20. He opined that based on Petitioner's physical examination, and without the benefit of reviewing a hip MRI before that examination, that Petitioner "clearly had an injury to some intra-articular structure of the [right] hip that could range the gamut from a tear of the labrum or cartilage to progressive arthritis." PX20 at 18. He also testified that he compared Petitioner's pelvic x-ray films and reviewed Petitioner's right hip MRI which he interpreted to show a large anterosuperior labral tear, chondromalacia (injury to the cartilage) and subchondral cystic changes. PX20 at 19-21.

Dr. Domb maintained the opinion expressed in his independent medical evaluation report that Petitioner's June 15, 2007 injury at work likely caused a labral tear and/or cartilage damage leading him to his current condition of fairly severe osteoarthritis of the right hip, which symptomatically speaking he noted to be incredibly severe. PX20 at 21-22, 24. He added that Petitioner's right hip condition was consistent with his work injury and the progressive degeneration occurring over the following five years. PX20 at 25. When asked whether the three-day delay in reporting any hip symptoms was significant, Dr. Domb also testified that in the vast majority of cases, whether the patient was injured at work or elsewhere, the patient did not usually realize that the hip was

the source of the injury including that it was the back or a groin pull. PX20 at 26-27. He explained that the hip is a very complex area of the body being quite close to the body's center and that there are 27 muscles that cross the hip. PX20 at 27-28. Dr. Domb testified that there are a variety of nerves that innervate the joint as well as the surrounding muscles and skin and that those nerves can, of course, be irritated in the back or around the hip, or both. *Id.* He also testified that there is a lot of crossover in the symptoms between pain that is coming from the back and pain that is coming from the hip. *Id.*

Dr. Domb also maintained his opinion that Petitioner required a minimally invasive robotic hip replacement. PX20 at 22-23. Dr. Domb also testified that this type of surgery was state-of-the-art and that Petitioner would be employable at least as a sedentary level during his 12-month postoperative recuperation; that is, that he would expect Petitioner to be back at a sedentary job within six weeks after surgery. PX20 at 23-24.

Dr. Domb also opined that Petitioner's antalgic gait following his various back surgeries over five years and his physical therapy regimen could or might have been contributing causes to the degeneration in the right hip condition. PX20 at 28. He also testified that Petitioner's right hip condition was causally related to his injury at work; that is, that it was more probable than not that there was a causal relationship based on the chain of events, Petitioner's lack of prior right hip symptoms, and the medical records he reviewed. PX20 at 28-29.

On cross examination, Dr. Domb acknowledged that he was unable to identify any particular movement or trauma to the right hip on the date of accident that would have directly and acutely injured Petitioner's right hip because he did not get into enough detail with Petitioner about the particular movement of the leg to theorize about it. PX20 at 38. However, he testified that his opinion was based primarily on Petitioner's lack of hip pain before his injury at work. *Id.*

Dr. Domb testified that there is a difference between groin and hip pain in that groin pain could be caused by something like a hernia, testicular problem, or a hip injury whereas hip pain usually identifies the source/origin of the pain, that is, the hip. PX20 at 34, 36. He also testified that labral tears can occur either suddenly and acutely or progressively over time, and that weight can be a risk factor for development of arthritis, but that he did not believe this was an issue in Petitioner's case because his other hip appeared to be perfectly fine. PX20 at 42-43, 48-49. He also testified that labral tears were generally caused by something suddenly or a repetitive problem, and that it was very rare to have an idiopathic labral tear. PX20 at 44-45.

On re-direct examination, Dr. Domb testified that an x-ray would not show an acute labral tear. PX20 at 46. He also testified that it is more probable than not that osteoarthritis was the *sequelae* of the labral tear due to further deterioration and cartilage damage over time and the leakage of fluid. PX20 at 47-48.

Deposition Testimony – Dr. Sporer

On October 25, 2013, Petitioner called Dr. Sporer as a witness at which time he provided testimony. PX19. He is a board-certified orthopedic surgeon with a hip replacement specialization. PX19 at 4-6 & Sporer Dep. Exh. 1.

Dr. Sporer testified about his examination of Petitioner, review of medical records and diagnostic films, and the opinions about Petitioner's right hip condition contained in his reports. *See generally* PX19. Dr. Sporer also opined that labral tears could be caused by trauma or degeneration and in cases of traumatic causes the tears could be caused or aggravated by twisting of the hip joint. PX19 at 21. He also opined that an acetabular rim or labral tear consistent with what was visualized in Petitioner's radiographs could be correlated to progressive loss

of cartilage and degenerative arthritis. *Id.* Dr. Sporer further testified that while 48 years of age is young for degenerative arthritis and Petitioner was not in the typical client age-range, it was something that he saw in patients in their late 40's. PX19 at 22-23. He also indicated that a plain x-ray would not show a labral tear. PX19 at 23.

Dr. Sporer opined that damage to a labrum has been shown to have increased stress on the hip joint which has been shown to lead to increased arthritis. PX19 at 23. With regard to the manifestation of groin symptoms, Dr. Sporer testified that the groin is the location where patients generally describe hip problems that are inside the joint and most patients that have either a labral problem or arthritis in the hip will complain of groin pain. PX19 at 23-24. He also testified that lumbar problems could potentially manifest as groin pain, but he had no specific opinion whether there was any correlation between Petitioner's back problems and his pathology. PX19 at 24-25.

Dr. Sporer acknowledged that he did not mention his review of a November 14, 2012 MRI scan in his report, but he did review the scan at the time of his deposition and he acknowledged that Petitioner's counsel's engagement letter indicated that a CD containing Petitioner's right hip x-ray and MRI were being included for his review. PX19 at 27-28, 35-36. On cross and re-direct examination, he testified that Petitioner's incident at work aggravated his underlying right hip condition and that Petitioner was a candidate for a total hip replacement; he declined to opine whether Petitioner would have needed a right hip replacement irrespective of his accident at work. PX19 at 31-34, 36-37, 39. Dr. Sporer further testified that Petitioner's accident may or could have, in fact, accelerated the time frame in which the need for surgery became necessary. PX19 at 39.

Deposition Testimony – Dr. Ghanayem

On October 30, 2013, Respondent called Dr. Ghanayem as a witness at which time he provided testimony. PX18; RX2. He is a board-certified orthopedic surgeon with a spine specialization. PX18 at 4-6 & Ghanayem Dep. Exh. 1.

Dr. Ghanayem testified about his examination of Petitioner, review of medical records and diagnostic films, and the opinions about Petitioner's low back and right hip condition contained in his reports. *See generally* PX18.

Dr. Ghanayem maintained his opinion that Petitioner had a new problem and began to develop right hip pain related to his hip arthritis which was not related to his injury at work. PX18 at 15. He also opined that Petitioner's MRI findings from November of 2012—taken in conjunction with the other objective and subjective information provided to him at the time he examined Petitioner and issued his reports dated July 12, 2012, August 23, 2012, and January 7, 2013—could not be attributed to a specific date of injury with the mechanism of injury described to him by Petitioner. PX18 at 24. He maintained his opinion that the mechanism of injury reported by Petitioner to him does not cause a labral tear and indicated that Petitioner did not have hip pathology complaints when he first saw Petitioner. PX18 at 27-29. Dr. Ghanayem added that Petitioner's reported mechanism of injury (i.e., coming out of a truck while holding on to a rail and steering wheel) does not induce the mechanism to pinch the labrum and impinge on the anterior acetabulum; that this mechanism of injury was the exact opposite of that to cause a hip problem. PX18 at 27-29, 85-86, 105-108.

On cross examination, Dr. Ghanayem acknowledged that he originally saw Petitioner for an evaluation and was asked to opine on Petitioner's back. PX18 at 66-69. Dr. Ghanayem also acknowledged that, after Petitioner's second evaluation with him in January of 2013, his report does not indicate what medical records he reviewed in rendering his opinions. PX18 at 72-73. He testified that he did not recall exactly what records he reviewed, but

that he would expect to have reviewed the records listed by Respondent's counsel in the engagement letters preceding issuance of his reports and that he returns those medical records. PX18 at 66-67, 73-77, 82-83, 87-88. He also testified that he did not mention reviewing any reports by Dr. Bernstein. PX18 at 89-92.

Dr. Ghanayem also opined on cross examination that Petitioner could not have suffered an intra-articular injury to the acetabular rim given his mechanism of injury or such an injury that further degenerated after years of medical treatment and physical therapy to the low back. PX18 at 101, 104. He opined that Petitioner's work injury could not have accelerated Petitioner's pre-existing right hip condition or that it was a contributing cause. PX18 at 101-103.

Additional Information

Petitioner testified that over the years of medical treatment, the surgeries helped alleviate some of his back pain, particularly the fusion surgery, but the groin pain continued to grow and worsened to the point that he now needs a cane to walk. Tr. at 76. On cross-examination, petitioner testified that his hip gives out and he started using a cane sometime after his last back surgery when his hip started really being a problem to prevent falls. Tr. at 92-93.

With regard to his current low back condition, petitioner testified that if he does anything physical for very long his entire back starts to lock up. Tr. at 83-84. He always has back pain. *Id.* Petitioner testified that he cannot do anything strenuous, sit, stand, or lay down for very long; he has to move around constantly. *Id.* He also testified that he sleeps in a chair and goes back to bed for a while before returning to the chair. *Id.* Petitioner further testified that regarding his low back and right hip, his pain radiates. Tr. at 84. He explained that while some of his lower back pain was relieved, the hip became more prominent and that is as radiating as much as it was before. *Id.*

Petitioner testified that he received benefits through April 30, 2013. Tr. at 85. Petitioner testified that he does not have group insurance and that the recommended right hip surgery has not been approved. Tr. at 63. He continues to see Dr. Gruft for pain management and receive narcotic medication including morphine and Norco for pain in his low back and right hip. Tr. at 78-80, 82-83.

ISSUES AND CONCLUSIONS

The Arbitrator hereby incorporates by reference the Findings of Fact delineated above and the Arbitrator's and parties' exhibits (AX1, PX1-PX20, RX1-RX19) are made a part of the Commission's file. After reviewing the evidence and due deliberation, the Arbitrator finds on the issues presented at trial as follows:

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

Several facts are undisputed. Petitioner has a labral tear in the right hip as of his November 2012 MRI. There is no evidence that he has a similar, or any, such condition in the left hip. He was a large man on the date of accident and, while he has lost some weight, continues to be so.

Moreover, Petitioner had no medical treatment to his right hip before June 15, 2007. He began reporting symptoms in the right hip and groin within days of his accident at work and continued to do so regularly throughout medical treatment. Petitioner's subjective reports of right hip pain and groin complaints of varying quality (i.e., burning, stabbing) to the physicians at the Clearing Clinic, Dr. Lorenz and his physician's assistant Mr. Pittman, Dr. Fronczak, and the physical therapists at MacNeal, ATI and Speckman are extensive and documented over about 5 ½ years. Petitioner made similar reports of right hip or groin pain to Dr. Bernstein, Dr. Domb, Dr. Sporer and, ultimately, Dr. Ghanayem.

While undergoing low back treatment, Petitioner also saw Dr. Bernstein on three occasions at Respondent's request for evaluation. Notwithstanding that the purpose of these evaluations was to evaluate Petitioner's low back condition, Petitioner reported right hip and or groin pain on all three occasions. Dr. Bernstein made at least some findings during those physical examinations related to the right hip. Respondent then selected a different Section 12 examiner, Dr. Ghanayem, whose first evaluation was also to focus on the low back. When he next saw Petitioner for an examination, Dr. Ghanayem was asked to address Petitioner's right hip condition and opine on its relationship, if any, to Petitioner's injury at work on June 15, 2007 or its *sequelae*. Petitioner was also evaluated by Dr. Domb and Dr. Sporer at his attorney's request.

There is no dispute between Dr. Domb, Dr. Sporer or Dr. Ghanayem, who opine on Petitioner's right hip condition, that he is in need of surgery for the right hip. All three doctors agree that Petitioner had some degree of right hip degeneration on the date of his accident at work. Even Dr. Bernstein noted that Petitioner's pelvic x-rays from January 22, 2008 show some evidence of arthritis and he made a recommendation for further diagnostics, but no such testing was performed. Most notably, however, all three physicians agree that Petitioner's right hip condition continued to degenerate, regardless of causation, over the following 5 ½ years before Dr. Lorenz's physician's assistant acknowledged Petitioner's ongoing pain and discomfort in the right hip and groin and ordered a right hip MRI. The same test that Respondent's Section 12 examiner, Dr. Bernstein, had recommended years earlier.

The divergence in Dr. Domb, Dr. Sporer and Dr. Ghanayem's opinions begins and remains whether Petitioner's right hip condition and his need for surgery stem, in whole or in part, from a traumatic hip injury sustained at work in 2007 causing a labral tear, whether he had pre-existing osteoarthritis that further degenerated during years of physical therapy and recuperation from multiple low back surgeries, or some combination of both. After careful consideration of the record as a whole, the Arbitrator finds the opinions of Dr. Domb and Dr. Sporer to be more persuasive than those of Dr. Ghanayem in this case and assigns more weight to their opinions.

In so finding, the Arbitrator notes that Dr. Domb opined in a somewhat hybrid fashion that Petitioner's right hip condition was "clearly" an injury to some intra-articular structure of the hip that could have been caused by anything from a labral tear to progressive arthritis. He maintained that Petitioner's June 15, 2007 injury likely caused a labral tear and/or cartilage damage leading him to his current condition of fairly severe osteoarthritis of the right hip, which he noted to be incredibly severe from a symptomatic perspective. Dr. Domb added that Petitioner's right hip condition was consistent with his work injury—although he acknowledged on cross examination that he knew little about the incident itself—and the progressive degeneration occurring over the following years.

Dr. Domb also testified, however, that patients with hip problems often report pain coming from the back or groin when the condition is actually in the hip. Dr. Sporer similarly noted that patients with labral tears will generally describe pain in the groin and that lumbar problems could potentially manifest as groin pain. The record reflects that Petitioner specifically and consistently reported right hip or right groin pain to every physician that examined him and almost every physical therapist that he saw for the entirety of the 5 ½ years that Dr. Lorenz addressed his low back condition.

The fact that Dr. Domb is Dr. Lorenz's partner at Hinsdale Orthopedics is not lost on the Arbitrator. Nor is the fact that Dr. Sporer reached his opinions while conceding that he did not have the benefit of reviewing Petitioner's November 2012 right hip MRI, which is the only diagnostic test that all three physicians agreed could reveal a labral tear. However, the Arbitrator finds it significant that Dr. Domb and Dr. Sporer specialize in hip conditions and surgical intervention unlike Dr. Ghanayem who last performed hip surgery as a resident and refers current patients in need of hip surgery to other colleagues.

While Dr. Ghanayem maintained his opinion that the mechanism of injury as he understood it could not cause a labral tear—and that the mechanism necessary to cause a labral tear would be the opposite of that described by Petitioner—the facts remain that Petitioner was asymptomatic in the right hip before his accident at work, there is no evidence that Petitioner exaggerated his subjective complaints to any physician, and even Dr. Bernstein—who did not evaluate Petitioner for the right hip at all—noted subjective right hip and groin complaints accompanied by painful range of motion in the right hip occurring long before Petitioner finally had a pelvic MRI in November 2012. The Arbitrator also finds it significant that Petitioner's testimony is corroborated by the medical records and independent medical evaluation reports, which contain no indication from any independent medical examiner, treating physician, pain management doctor, physician's assistant, physical therapist, or counselor that Petitioner's subjective reports were distorted when compared to objective data or that he malingered over these many years.

In light of all the foregoing, the Arbitrator attributes little weight to Dr. Ghanayem's contention that Petitioner had a new onset of groin pain and does not find his opinions to be as persuasive as those of Drs. Domb and Sporer given the totality of the evidence in this case and finds that Petitioner has established by a preponderance of credible evidence that his current right hip condition of ill being is causally related to his accident at work.

In support of the Arbitrator's decision relating to Issue (K), Petitioner's entitlement to prospective medical care, the Arbitrator finds the following:

As explained above, the Arbitrator finds that Petitioner's current right hip condition of ill being is causally related to his June 15, 2007 accident as claimed. Thus, the Arbitrator awards the prospective medical care related to the right hip recommended by Dr. Domb and Dr. Sporer pursuant to Section 8(a) of the Act as it is reasonable and necessary to alleviate Petitioner from the effects of his injury at work.

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

As explained above, the issue of causal connection between Petitioner's current right hip condition and his June 15, 2007 accident has been resolved in Petitioner's favor. Moreover, the record does not reflect that Petitioner's right hip condition has yet stabilized or reached maximum medical improvement. Thus, the Arbitrator finds that Petitioner is entitled to temporary total disability benefits commencing May 1, 2013 through November 19, 2013 as claimed.

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

Perla Reyes,
Petitioner,
vs.
Kiki-D's Barbecue House, Ltd.,
Respondent,

NO: 10 WC 42589

15IWCC0003

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, penalties, temporary total disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 22, 2014 is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $52,400.00. 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: JAN 5 - 2015

MB/mam
o:11/6/14
43

Maria Basurto

David L. Gore

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

REYES, PERLA
Employee/Petitioner

Case# **10WC042589**

15IWCC0003

KIKI-D'S BARBECUE HOUSE LTD
Employer/Respondent

On 4/22/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% 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:

1922 STEVEN B SALK & ASSOC LTD
150 N WACKER DR
SUITE 2570
CHICAGO, IL 60606

0532 HOLECEK & ASSOCIATES
FRED NORMAN
161 N CLARK ST SUITE 800
CHICAGO, IL 60601

STATE OF ILLINOIS)
)
COUNTY OF COOK)

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

15IWCC0003

ILLINOIS WORKERS' COMPENSATION COMMISSION
DECISION AND OPINION ON REMAND

Perla Reyes
Employee/Petitioner
v.
Kiki-D's Barbecue House, Ltd.
Employer/Respondent

Case # **10** WC **42589**

This matter came before me on January 30, 2014 in the City of Chicago pursuant to a remand from the Circuit Court of Cook County and pursuant to a remand from Illinois Workers' Compensation Commission. After reviewing all of the evidence presented by the parties, reviewing the parties' proposed decisions, and conducting due deliberations, I hereby find that:

Pursuant to the Circuit Court's order and the Commission's instructions, the fee schedule amounts due to Marque Medicos is $21,738.03, to Specialized Radiology Consultants is $208.41, to Medicos Pain & Surgical Specialists is $7,224.62, to Metro Anesthesia is $3,579.34, to Archer Open MRI is $6,376.13, to Prescription Partners is $3,096.08, to Dr. John F. Kane is $3,955.70, and to Ambulatory Surgical Care Facility is $17,877.52 for a total fee schedule amount of $64,055.83.

Pursuant to the Circuit Court's order and the Commission's instructions, Respondent shall pay to Petitioner $13,847.96 as provided in Section 16 of the Act; $34,619.91 as provided in Section 19(k) of the Act; and $3,780.00, as provided in Section 19(l) of the Act.

A record of the hearing was made.

PROCEDURAL HISTORY

This is the second hearing before this Arbitrator. The first arbitration was heard, pursuant to Section 19(b), on the issues of accident, notice, causal connection, earnings, medical expenses, temporary total disability, and penalties. This Arbitrator's decision of February 25, 2011 made findings of accident, notice, and causal connection, determined earnings, awarded one week of temporary total disability benefits, awarded medical benefits through November 5, 2010, and denied penalties. Petitioner filed a review. On December 30, 2011, the Commission issued a review decision, modifying the award of temporary total disability to 5 6/7^{ths} weeks, modifying the award of medical benefits through December 10, 2010, and affirming all else. Petitioner

filed a writ to the Circuit Court. On December 27, 2012, the Circuit Court found that it was against the manifest weight of the evidence to terminate temporary total disability benefits and medical benefits as of December 2, 2010 and that Petitioner was entitled to penalties. The Circuit Court reversed and remanded for further proceedings consistent with that order. On May 31, 2013, the Commission issued a Decision And Opinion On Remand. 15IWCC0003

The Commission found no basis in the record to change any of its decision, however pursuant to the Circuit Court's instructions the Commission awarded temporary total disability benefits through February 11, 2011 and awarded additional medical benefits, so long as the bills were subjected to the medical fee schedule. The Commission denied certain bills for chiropractic treatment for which there was no prescription and which were provided simultaneously and excessively with physical therapy and denied bills for an electrocardiogram, urinalysis, a pregnancy test, and nonemergency transportation costs as not causally related. Pursuant to the Circuit Court's instructions, the Commission found that Petitioner is entitled to penalties and attorneys fees. The Commission found that it would be premature to calculate the penalties and attorneys fees and remanded to the Arbitrator to receive limited additional evidence in support of the outstanding medical bills which were specifically noted and were adjusted to the fee schedule, so that once the medical amounts were known a proper determination would be made by the Arbitrator of the penalties and attorneys fees due and owing.

Thereafter there were additional pretrial Arbitration proceedings, at which time this Arbitrator advised Petitioner's counsel that a proposed preprinted medical fee schedule analysis, standing alone, would be insufficient to meet the evidentiary requirements of the remanding orders.

STATEMENT OF FACTS

At the January 13, 2014 hearing, Petitioner called a witness, Nataliya Curchiy. On direct examination she testified that she is a certified professional coder employed by Premier Billing Solutions. She testified regarding her curriculum vitae (PX1), and she testified about a preprinted medical fee schedule analysis (PX2). She testified that Premier Billing Solutions performs medical coding and fee schedule analysis for Marque Medicos, Medicos Pain & Surgical Specialists and Ambulatory Surgical Care Facility. She testified that she is familiar with the Illinois Workers' Compensation fee schedule. She testified that she codes medical procedures and determines billing pursuant to the fee schedule of the Illinois Workers' Compensation Act.

She testified that she reviewed the bills of the medical providers awarded by the Commission on remand and that the balances listed on PX2 dated January 13, 2014 are fee schedule balances in accordance with the Illinois Workers' Compensation fee schedule. She testified that the fee schedule amounts due to Marque Medicos is $21,738.03, to Specialized Radiology Consultants is $208.41, to Medicos Pain & Surgical Specialists is $7,224.62, to Metro Anesthesia is $3,579.34, to Archer Open MRI is $6,376.13, to Prescription

Partners is $3,096.08, to Dr. John F. Kane is $3,955.70, and to Ambulatory Surgical Care Facility is $17,877.52. She testified that the total fee schedule amount due is $64,055.83.

On cross-examination she testified that all of her work is for Premier Billing Solutions, which gets ongoing business from Marque Medicos, Medicos Pain & Surgical Specialists, and Ambulatory Surgical Care Facility. She testified that she handles all of their billing and coding requirements, outstanding of any others. She testified that there is a common ownership and management with the same president and same CEO.

MEDICAL FEE SCHEDULE AMOUNTS

This Arbitrator finds no basis in the record to change his decision regarding medical benefits. However, pursuant to the Circuit Court's order and the Commission's instructions this Arbitrator finds that the fee schedule amounts due to Marque Medicos is $21,738.03, to Specialized Radiology Consultants is $208.41, to Medicos Pain & Surgical Specialists is $7,224.62, to Metro Anesthesia is $3,579.34, to Archer Open MRI is $6,376.13, to Prescription Partners is $3,096.08, to Dr. John F. Kane is $3,955.70, and to Ambulatory Surgical Care Facility is $17,877.52 for a total fee schedule amount of $64,055.83.

The testimony in support of the preprinted medical fee schedule analysis was unrebutted.

PENALTIES AND ATTORNEYS' FEES

This Arbitrator finds no basis in the record to change his decision regarding penalties and attorneys' fees. However, pursuant to the Circuit Court's order and the Commission's instructions this Arbitrator finds that:

Section 19(l) penalties of $30.00 per day are due from the first date of temporary total disability, October 23, 2010 through the date of the hearing, February 25, 2011, for a total of 126 days, which equals $3,780.00.

Section 19(k) penalties of 50% of $64,055.83 are due for unpaid medical bills, which equals $32,027.91.

Section 19(k) penalties of 50% of 16 weeks are due for unpaid temporary total disability benefits at $324.00 per week totaling $5184.00, which equals $2592.00.

Section 16 attorneys' fees of 20% of $64,055.83 are due for unpaid medical bills, which equals $12,811.16.

Section 16 attorneys' fees of 20% of 16 weeks are due for unpaid temporary total disability benefits at $324.00 per week totaling $5184.00, which equals $1,036.80.

This Arbitration Decision is based exclusively on evidence in the record of proceeding and material that has been officially noticed.

Unless a *Petition for Review* is filed within 30 days from the date of receipt of this order, and a review perfected in accordance with the Act and the Rules, this order will be entered as the decision of the Workers' Compensation Commission.

15IWCC0003

Signature of arbitrator

April 21, 2014
Date

APR 22 2014

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 down-limited CC	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Joseph Moyers,

Petitioner,

15IWCC0004

vs.

NO: 10 WC 14758
10 WC 42786

Rock River Disposal,

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, causal connection, notice, temporary total disability, medical expenses, and prospective medical care, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

- Petitioner was a 32 year old employee of Respondent, who described his job as a mechanic. Petitioner was employed by Respondent for nine years as of the date of accident. Petitioner indicated that Respondent's business is a garbage hauling facility and Petitioner was a mechanic who performed all repairs except engine repairs, on the trucks. On the date of accident, March 12, 2010, Petitioner testified that he was directed to repair

a vehicle that was owned and operated by Respondent. He stated he was called out to Mitchell Road and 173. Petitioner testified that he drove (alone) Respondent's service truck to the location from the shop where he had been doing other things. Petitioner testified that it was common to get a call about a disabled truck. When he arrived on the scene he stated he observed a truck on the side of the road and the truck was not running; the driver of that truck was Justin Wilkins. Petitioner testified he did his assessment of the truck; he looked it over and checked the battery; everything had checked out okay. Petitioner stated they had just gotten that truck back from Rockford Truck Sales to it was just being run to see how it would go. Petitioner indicated he was unable to make repairs on site and he was unable to get the truck started; the truck had to be towed. When he could not get the truck running, Petitioner called the supervisor, which was standard operating procedure. He had called for Butch Taylor but he was not there that day so Petitioner talked to another supervisor, Mike Garrison. Petitioner called Mr. Garrison via 2-way radio. Petitioner indicated that the truck needed to be towed and before it could be towed he had to remove the drive shaft and axles. Petitioner stated that when he arrived the vehicle was not running. Petitioner testified that he first pulled the fuel filter and found brass shavings inside which indicated something was coming apart. Petitioner replaced the fuel filter and then had called Mr. Garrison and advised him that the truck needed to be towed to the truck station. Petitioner stated that after he got off the radio with Mr. Garrison he went back to the service truck, retrieved his tools, returned to the disabled truck and pulled the axles out of the vehicle and then went to remove the drive shaft. Petitioner testified he was under the vehicle to remove the drive shaft. He was on a creeper that he laid on to be directly under the shaft. He indicated there are four bolts which he had to remove from each end of the shaft to remove it. Petitioner stated that the rear end side it is a lot closer to the ground and he got that out with no problem. Petitioner testified that when he was taking off the transmission side he was holding it up with his right hand and when he took the last bolt off, it skipped out of the U-joint unexpectedly. He stated that rather than the shaft landing on him he tried to guide it off to the side and that was when he felt something shoot through his right shoulder. Petitioner is right hand dominant. Petitioner testified that the drive shaft weighs 100-150 pounds. Petitioner indicated that usually you have to pound to get the shaft out but it came out unexpectedly, it just flipped out and he was not ready for it and he just caught it and let it back on the ground next to him and that was when he felt the pain in his right shoulder. The vehicle cannot be towed with the shaft on or it will turn while towing and ruin the transmission.

- Petitioner testified that when it happened he felt pain and told the driver that he had just done something to his shoulder and did not know what. Petitioner testified the driver helped Petitioner get the drive shaft back into the truck and then Petitioner stated he told Mike Garrison (via radio) that something had happened to his shoulder and that he needed to go to the clinic. Petitioner indicated that Mr. Garrison told him to drop the driver off at the shop before Petitioner went to the clinic. Petitioner testified that there was no doubt in his mind that Mr. Garrison understood he was reporting that something had happened to his shoulder that day as a result of what he was doing at that site. The

driver, Justin, helped Petitioner get the drive shaft to the service truck and Petitioner drove Justin back to the shop to drop him off. Petitioner stated that he then went to Brookside Immediate Care as instructed to by Mr. Garrison. Petitioner indicated that was the clinic Respondent sent people to for work injuries. Petitioner stated that he had gone straight to Brookside after dropping off Justin.

- Petitioner testified that when he got to Brookside he told them he was there from Respondent and that he had hurt his shoulder and needed to see a doctor. Petitioner stated that he filled out some paperwork and a lady brought him to the other side of the counter and wanted a history of what was going on with Petitioner's shoulder. Petitioner testified that he told her that he had been taking a drive shaft out and something had let go in his shoulder and he could feel his heart beating in his shoulder. Petitioner stated he told her it hurt really bad. Petitioner stated he began to tell her that he had started to feel something in his shoulder prior to that, but the prior was nothing major, nothing that he could not deal with before. Petitioner stated she asked when he started to have that feeling and he stated that he really did not know an exact time, maybe a month before, but it was not on a Sunday as they do not work on Sunday's. He indicated her questions then were directed to any symptoms in his shoulder prior to March 12, 2010 and Petitioner stated he was describing to her what had happened that day. Petitioner testified that prior to leaving the clinic that day he was not shown any medical records, history or electronic dictation from that visit. Petitioner stated that he had not reviewed the medical records of that visit until at least a year later after he had retained an attorney. Petitioner did not recall if he had one follow up visit there after the initial visit on the date of the accident.

- Petitioner then came under the care of Dr. Freedburg at Suburban Orthopedics on March 31, 2010. Petitioner testified he advised the doctor of what had occurred; Petitioner recalled telling the doctor of the episode on March 12, 2010. (Petitioner had apparently been referred there by his primary doctor, Dr. Strutzenberg). Petitioner continued to treat with Dr. Freedburg from March 2010 through about July 2010. Petitioner had received an MRI of his shoulder and an injection. Therapy had also been prescribed, but the therapy then made his symptoms worse and the injection did not do anything. Petitioner testified he last saw Dr. Freedburg July 2010 and had not seen him since that time.

- Petitioner testified that he remained on light duty under the care of Dr. Freedburg until his FMLA time had expired (about 12 weeks—Lost time about March 17, 2010 through late June 2010); Respondent had no light duty work for Petitioner. After his FMLA expired Petitioner returned to work full duty at Respondent. Petitioner testified that he had been released to full duty (June 28 or 29) when his FMLA time was up; he had to return to work then or he did not have a job. Petitioner had continued working for Respondent for about 2.5 years after his return (to about January 12, 2012, his last day of work for Respondent). Petitioner quit voluntarily at that point. Petitioner testified that from June 2010 through January 12, 2012 he had worked full duty for Respondent as a mechanic. Petitioner testified that since he left Respondent he had worked nothing

consistent; he worked a couple driving jobs here and there and some small mechanical, but that was about it. As of the date of this hearing, Petitioner was not working.

- Going back to March 12, 2010, Petitioner testified that when he left the site in his service truck with the driver, the broken down truck was still there as it had not been towed yet. Petitioner again indicated he had not seen Dr. Freedburg since July 2010 and he had received no medical treatment regarding his shoulder from then through this hearing. Currently Petitioner testified that if he pushes or pulls real hard, he feels a sharp pain; with just rotating it around, something in there cracks and pops. Petitioner testified that there was no doctor currently recommending any treatment and he was not taking any pain medication or over-the-counter medication.

- Mr. Garrison, testified for Respondent. Mr. Garrison stated that he last worked at Respondent in September 2012. He appeared via subpoena. Mr. Garrison was familiar with Petitioner. Mr. Garrison had worked for Respondent for 12 years and his duties in 2010 was as route supervisor. Mr. Garrison stated he was in charge of getting the drivers out in the morning, making sure they all had maps, knew what they were doing, assigning duties, and taking care of calls. Mr. Garrison stated the he started in the morning at the base which was Respondent's shop/repair shop on South Main Street. He, however, was not normally in a fixed location; he was usually out in the field in the pickup truck.

- Mr. Garrison testified his routine day was to go in about 5:00am and make sure all the maps were all set out and wait for the guys to call in and things to arise. He stated the guys would start coming in at 5:30 and they stretched. He stated after a little stretching for 10-15 minutes, the guys went to their trucks and came to him or another supervisor with any questions, like routes that day or certain notes or anything special to watch for that day, and then the drivers would leave. Mr. Garrison indicated if there were totes or recycle bins missed from the prior day they need to be checked out and he would go in the pickup truck and take over all the papers. He also stated that he had bins in the back of the truck, and he would take off with his list and start delivering and picking up stock and things and check on the drivers. Mr. Garrison testified that most of his day was out on the road and he would return every evening when the routes had been done; there was never a set time, it depended on when the drivers were getting in. It was determined by radio and they had a list of the drivers and the route numbers. If a driver called in to say he was done, Mr. Garrison would cross him off the list. His supervisory responsibility was primarily for the drivers. He was not Petitioner's immediate supervisor; he indicated at the time Butch Taylor was Petitioner's supervisor (early 2010). Petitioner's testimony was discussed regarding March 12, 2010. He testified he was familiar with a lot of trucks being towed. He indicated he could not specifically say exactly what happened on March 12, 2010, but he could not say that it did not happen. Mr. Garrison testified that he did recall a conversation with Petitioner regarding Petitioner's hurting his shoulder regarding removing a drive shaft from a truck. He did not recall how he was contacted about it or who called him, but he knew he went back to the shop as he had been out in the field. Mr.

Garrison stated he had gone back to the shop and that was when he talked to Petitioner about his shoulder, but he did not recall who contacted him about it. Mr. Garrison stated that he talked to Petitioner in the shop. Mr. Garrison testified, to the best of his recollection that Petitioner said he hurt his shoulder pulling out a drive shaft, so Mr. Garrison told Petitioner that he need to go to the clinic and had directed Petitioner to Brookside as that was standard that any injuries go there. Mr. Garrison testified he did not learn anything more from Petitioner that day and he did not recall any other conversations. He did not recall, the time the conversation with Petitioner took place at the shop. Mr. Garrison did not recall Petitioner telling him about any prior problems with the shoulder. Essentially he had been substituting as supervisor for Mr. Taylor; Mr. Garrison indicated he was the only supervisor in the shop then. As to learning of the incident, he did not recall if someone called and said he needed to see Petitioner as he was hurt, or someone called and said there was a driver in the shop because his shop was not working; he did not recall why he was called back to the shop, he just knew he had returned to the shop when he learned of Petitioner's injury. He indicated that would have been earlier than he would normally have returned to the shop. He did go back to the field afterwards; he recalled going back out because he was talking to risk management when he was going back out, he did recall that.

- Mr. Taylor, testified for Respondent. Mr. Taylor testified that he was employed by Respondent in 2010 and had worked there from April 2008 to when he left Respondent in April 2011. In early 2010 he was familiar with Petitioner as they worked together in the shop and he was Petitioner's immediate supervisor. Mr. Taylor testified he would prioritize the repair work to be done, create work orders, work with vendors as to parts supplies, outside labor, and such things. Mr. Taylor testified he was responsible for supervising all the mechanics; he believed there were five. If anyone had a work related injury he asked the employee to report it to him and Mr. Taylor had some simplified field paperwork he would fill out to the best of his ability (get information about the date, type of injury, and who was involved) and he would then forward that information to the risk management division at the William Charles Company. Mr. Taylor testified he did not work March 12, 2010; it was a Friday. He agreed Garrison had contact with Petitioner that day but Garrison was also supervisor over the drivers. Mr. Taylor testified he worked Monday, March 15, 2010 and he testified that early that morning Garrison reported to him that Petitioner reported an injury to Garrison on Friday and Garrison had sent Petitioner to Brookside for assessment of the injuries. Mr. Taylor testified he asked Garrison if he had done anything as far as the reporting paperwork and Garrison indicated he had already filled out a first report of injury. Mr. Taylor testified he had created a field report based on the information he had been supplied and he believed he had forwarded that to Karen Cox in risk management. Mr. Taylor testified March 15 or March 16 he talked to Petitioner about the injury and Petitioner indicated he had removed a drive shaft out of a truck. He stated he asked Petitioner about the date of injury and Petitioner stated it was in January of that year and Mr. Taylor stated they thought it was March 10. He stated he advised Petitioner to make sure of the date to keep the date the same. He had

created a daily journal of the specifics of the conversations or work activities that he had provided to the attorney; he had always used a journal as a supervisor. He believed he had something written there on March 15. He viewed RX 6 and identified it as a copy of his original 2010 journal. He stated he prepared that on a daily basis and he still does. Mr. Taylor stated he daily records conversations with vendors that he deems important, days off for employees, injuries for employees and such things. He indicated it was his handwriting and no one else makes entries in his journal. Mr. Taylor testified that on March 12 he noted 'north' and he stated he is a snow-mobiler and he was up north for a long weekend then. He noted his March 15 and 16 entries. He noted his January 25 and January 26 entries. The March 15 entry was the first day he spoke to Petitioner and he also had a conversation with Julie V., risk manager. He indicated there that Petitioner went to Brookside March 12, 2010 for a shoulder problem. The March 15, 2010 entry again noted Petitioner and the conversation that Petitioner thought it may have been done on January 25, 2010; there was no first report of injury and he had no notes from 1/10. He stated he and Petitioner talked a little more and he asked Petitioner how he came up with the date and Petitioner stated he had to tell the doctor some sort of date and did not know exactly when he did it but he thought it was with a drive shaft. Mr. Taylor stated he talked to Karen Cox in risk and asked about a first report of injury or something he was not aware of and she did not have one. He stated he talked to Julie Vernetti later that day and she told him the claim was going to be denied as there was no first report, after 6 weeks and she was providing a job description pending a doctor release.

- Mr. Taylor agreed they were talking about a Volvo truck to be towed. He supervises the shop and he is familiar with the vehicles and aware of the process to get a vehicle ready to be towed. Mr. Taylor stated if a truck engine will not run, it needs to have the drive line disconnected or drive shaft in some method. He stated if the engine is not running the automatic transmission will have no oil pressure so if towed down the road the gears in the differential will allow the transmission to turn. He stated so you have to eliminate the possibility. One way is to disconnect the drive shaft at the differential or more frequently they pull the axle at the hub to achieve the same thing, to protect the drive line and prevent further damage to the transmission. Removing the axle would be sufficient. Mr. Taylor indicated he had further conversation with Petitioner March 16. He met Petitioner at 6:45am regarding the WC on his right shoulder. He stated he quoted Julie Vernetti that it was not going to be workers' compensation as no report was provided until after 6 weeks. He advised Petitioner, per Julie, to seek treatment from his own doctor and then obtain a release for the shoulder and he also asked for a job description of Petitioner's job duties. He again questioned March 12 and told Petitioner to keep the dates and story the same. No one else was present in the shop when he talked to Petitioner that day. His conversations with Julie and Karen Cox had been via phone. He indicated Julie from risk asked him to pull records from January 2, 2010, through March 16, 2010 and he was directed to send Petitioner home pending a doctor appointment March 17, 2010. Mr. Taylor stated that Petitioner left at 11:00am from the shop. Mr. Taylor indicated to remove the axle you do not have to get under the vehicle but you do for the drive shaft.

Mr. Taylor indicated that he had a conversation about the situation with Eric Sundberg (Teamster business agent) that same day and advised him that Petitioner was sent home pending the outcome. He indicated that Petitioner had a doctor appointment March 17 and he talked to Petitioner on the phone; Petitioner had to postpone the doctor appointment to the next day. Petitioner advised him Petitioner had an MRI appointment March 18, 2010 with his doctor. Mr. Taylor was aware Petitioner was off from then until the end of June. He noted that on June 28, 2010 when Petitioner reported for work 12:30pm he did not have a doctor release with him. Mr. Taylor stated that he called HR which did not then have a release. Mr. Taylor testified that at 1:55pm HR faxed the doctor's release and Petitioner was allowed to return to work.

- Mr. Taylor, to the best of his knowledge, indicated Petitioner then continued to work until January 2012 (about 1.5 years) at full duty as a mechanic. Mr. Taylor viewed RX 1 and indicated it was the first report of injury for Petitioner; he did not prepare that report, but had seen it. He indicated the information on the report was correct and based on the information he knew. It has 2 dates of alleged injury noted, March 12, 2010 and January 25, 2010. He indicated the dates as alternatives. Mr. Taylor agreed it correctly described that Petitioner complained about his right shoulder. He noted that is the form used to report injuries and it was filled out March 15, 2010. He viewed RX 2 and noted it was a document he had filled out; he indicated those different date notes were noted independent of his log and accurately recorded the conversations, he believed, with Petitioner in his investigation. Mr. Taylor viewed RX 3 and indicated it was a service/work ledger of duties performed by specific mechanics. He would record the work order; the mechanic doing the repairs prepared the form; Petitioner's clock number 10,071 was noted. He noted the entries of the work Petitioner performed that day. He agreed there was nothing noted January 25, 2010 regarding a drive shaft. Mr. Taylor indicated that to his understanding those tasks are noted in chronological order of the tasks done, when the work was done (roughly half hour increments). He indicated the same was true for the March 12, 2010 described events. He understood per the record that Petitioner noted a motor problem with truck 40141 at 11:00-12:30, and the vehicle was towed to International so he presumed Petitioner had responded to that call for the problem. He noted after that Petitioner noted two brake adjustments on another truck (40258), he indicated that could have been done in the shop. He indicated the last entry 40142 could have been in the field or shop. The times were indicated and he stated that those later work jobs were done after the towing incident. Mr. Taylor was not aware of Petitioner taking any further time off work regarding his shoulder after his return.

- Two private investigators testified regarding their surveillance and video's of Petitioner.

- Various exhibits, including medical records and depositions, were presented at this hearing.

The Commission notes, that regarding the two case numbers, that these are duplicate filings for the same date of accident

The Commission finds regarding accident and causal connection that Petitioner testified of the specific mechanism of injury March 12, 2010 removing the drive shaft of the truck. The consistent history is reflected in the medical records, but the date with the initial visit is indicated in January rather than March. Respondent's witnesses indicated a similar mechanism of injury and being notified in March, but they referred back to January as a date. The Form 45 indicated both a January and a March date of accident with a consistent history of the testified mechanism of injury. Petitioner's testimony is unrebutted and supported in the evidence and testimony as to the mechanism of injury. The records of the towing company and Respondent/Petitioner's work logs indicate he would have done the removal of the drive shaft for the tow on March 12, 2010 with no indication of any activity like that in January. The evidence and testimony in this record supports Petitioner's testimony. Also it would be strange for the accident to have occurred in January and Petitioner continue to work through to March 12, 2010 doing his regular work if the injury was of significance in January. The more apparent picture is that Petitioner was having some discomfort in his right shoulder for a period of time prior to March 12, 2010 but when the drive shaft (100-150 pounds) fell and he caught it and then injured his right shoulder which then caused the significant pain and discomfort that sent him to Brookside Clinic on March 12, 2010. The described mechanism could appear as something to have aggravated his prior minimal problem that he had not even sought medical treatment in January; Dr. Freedburg's records and testimony is of the mechanism of injury and a causal relationship to the March event. Petitioner testified he had to give a date at the clinic regarding when his symptoms first began and he came up with the January 2010 date, but it does seem odd that the clinic would not record the March 12, 2010 incident (the same day) which made him seek medical treatment. However, Respondent's witnesses indicated they did not see Petitioner favoring his right arm until he had reported the incident March 12, 2010 and again March 15, 2010. Also, Respondent's, Mr. Garrison testified, to the best of his recollection that Petitioner said he hurt his shoulder pulling out a drive shaft, so Mr. Garrison told Petitioner that he need to go to the clinic and had directed Petitioner to Brookside as that was standard that any injuries go there. Further, for the March 12, 2010 accident, the Brookside records clearly noted objective findings of a limited range of motion and significant pain with abduction against resistance which also supports the accident occurred March 12, 2010 and also supports a finding of at least some causal relationship to at least a strain/sprain/aggravation. The MRI noted the acromion contusion and bicipital tendinitis as further support of the injury and the March accident date rather than the January date. Despite the date issue/inconsistency, the evidence and testimony still evidences an accident that occurred March 12, 2010 to find Petitioner met the burden of proving accident that arose out of and in the course of employment on that day and also provided timely notice.

The Commission notes that this §19(b) hearing occurred July 22, 2013and Petitioner last sought treatment in July 2010. This hearing, therefore, being about three years from his last treatment date of treatment. Dr. Freedburg released Petitioner to full duty at that time and Petitioner did, in fact, return to work for Respondent (for about a year and a half) in his full capacity until he

voluntarily resigned (for no expressed reason); he was last employed by Respondent January 12, 2012 (about 1.5 years prior to this hearing). The surveillance video did not show Petitioner doing anything of significance with his right arm through July 2010, but it also did not indicate any favoring of his right arm either. Petitioner testified of doing various jobs and things since he stopped working for Respondent. Dr. Freedburg's records did note the treatment options from the beginning; that surgery had been a possible option, but Petitioner had opted for the conservative care with medication, therapy, and injections, which apparently did not help, per the records and testimony. The February 11, 2011, medical report of Dr. Freedburg to Petitioner's attorney, noted the March 12, 2010 accident as the mechanism of the injury described; Pain constant 5/10 and he indicated the exam noted positive pathology. Dr. Freedburg noted the diagnosis as right traumatic bicipital tendinitis with bone contusion to acromion, rotator cuff tear. Dr. Freedburg opined a causal connection between the described injury and condition of ill-being. Dr. Freedburg noted that the MRI did not show a rotator cuff tear but he further stated an MRI arthrogram down the road would prove it. Dr. Freedburg stated, that more importantly, Petitioner does have bicipital tendinitis and possible SLAP lesion that he thought would be in need of surgical intervention. Regarding further care, Dr. Freedburg stated Petitioner was in need of care and thought would require surgery for his condition, rotator cuff evaluation and a possible distal clavicle resection. Dr. Freedburg further stated he did not believe Petitioner was at MMI until after surgery and he again opined a causal connection between the accident and the condition of ill-being. There is no indication Petitioner had been seen in February 2011 so Dr. Freedburg's opinion there was made over six months since he last saw Petitioner.

The Commission notes Respondent's §12 examiner, Dr. Weiss noted, April 14, 2011, that Petitioner reported he injured his right shoulder while working when a drive shaft fell while he was removing it. Dr. Weiss noted the discrepancy regarding the date, but also noted that Petitioner had not improved with conservative care and arthroscopy was recommended. Dr. Weiss indicated the MRI did not officially show a rotator cuff tear but showed contusion of acromion, and the exam revealed atrophy and slight restriction of external rotation and positive impingement sign. Dr. Weiss noted Petitioner's current complaints of pain and weakness of the right shoulder and that Petitioner indicated not having constant pain, but Petitioner had right shoulder pain if he used it a lot or elevating his arms or in awkward positions like reaching for a seatbelt, putting on a sweater or using a hammer. Dr. Weiss diagnosed impingement syndrome right shoulder; resolved contusion right acromion and supraspinatus and infraspinatus atrophy. Dr. Weiss stated that he believed surgical intervention would probably be required to alleviate the condition and stated there was some evidence of some disability but premature to determine. As to a causal relationship Dr. Weiss noted several issues puzzling. He noted that the discrepancies regarding the date of injury and job activities are significant and as a result he was unable to determine factually whether or not injury occurred as described. He indicated also that a bony contusion on MRI would usually be visible at least 3 months after occurrence and therefore could have occurred in January or March 2010. He indicated that if Petitioner suffered a contusion it would be expected to resolve in 3-6 months; he did not see how the accident would produce impingement or rotator cuff atrophy. Dr. Weiss indicated obviously the contusion could not have caused the discomfort that pre-dated the incident. Dr. Weiss found no evidence of

bicipital tendinitis noted the prior year by Dr. Freedburg. Dr. Weiss believed the traumatic event, if it occurred, caused a shoulder contusion which had resolved. Dr. Weiss opined no definite cuff tear, though it theoretically would be possible. Dr. Weiss indicated that the atrophy was likely a result of degenerative process rather than the described incident and further stated Petitioner had not yet reached maximum medical improvement (MMI) as arthroscopy would be appropriate for impingement syndrome but based on current information he did not believe it related to alleged injury of March 12, 2010.

The Commission finds that there is evidence of some ongoing causal relationship, but Petitioner had not sought medical treatment since July 2010 and the most recent medical opinion from Dr. Freedburg was February 2011, without apparently even then seeing Petitioner. Again, as noted, Petitioner had returned to regular unrestricted duty for Respondent from late June 2010 until his voluntary resignation January 12, 2012 and thereafter continued to pursue various temporary sorts of work and activities. The Commission finds it, at best, difficult to accept a medical opinion (February 2011) rendered almost two and a half years prior to the hearing (without even examining Petitioner), and now, about three years from the last treatment. Additionally, in light of Petitioner continuing to pursue job duties, one would question how he continued to do that if his symptomology was as significant as claimed, without seeking further care of some sort before now. The evidence and testimony does find Petitioner met the burden of proving a causal connection, but not to the current condition of ill-being. A current causal relationship, given the long span without treatment and later work history, is not evidenced now to find an MRI arthrogram and possible surgery to be reasonable and necessary with such outdated medical opinion given the facts and circumstances presented here. Petitioner proved a causal relationship to an acromion contusion and bicipital tendinitis, (maybe some aggravation of his prior untreated shoulder discomfort issues), which per the opinion of Dr. Weiss would have found Petitioner at maximum medical improvement (MMI) three to six months post injury. The Commission, therefore, finds the decision of the Arbitrator as not totally contrary to the weight of the evidence as to accident and some causal relationship, and the Commission, herein, affirms and adopts the Arbitrator's finding of accident, March 12, 2010. Further, the Commission, herein, affirms and adopts the Arbitrator's finding, but as to some causal connection, not to his current condition of ill-being; MMI per Dr. Weiss about 6 months after the March 12, 2012 (so about September 2010 being the date of MMI) and the Commission, herein, modifies the decision as to no ongoing causal connection to his current condition of ill-being thereafter.

The Commission finds, as to notice, as noted above, there is evidence of timely notice of a March 12, 2010 accident and Respondent's Form 45 even indicated two possible dates of injury with the March date included. 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 of timely notice.

The Commission, with the findings above of accident, some causal connection, and timely notice, finds in regard to temporary total disability (TTD) that the Petitioner met the burden of proving entitlement to the TTD as awarded. The Commission finds the decision of the Arbitrator

as not contrary to the weight of the evidence, and, herein, affirms and adopts the Arbitrator's finding as to total temporary disability.

The Commission, with the findings above of accident, some causal connection, and timely notice, finds in regard to medical expenses/prospective medical care that Petitioner met the burden of proving entitlement to the medical expenses incurred, but not to any prospective medical care. The Commission finds the decision of the Arbitrator as contrary to the weight of the evidence as to an ongoing causal connection to his current condition on ill-being and need for prospective medical care or testing, given evidence that Petitioner reached maximum medical improvement by September 2010. The Commission, herein, affirms and adopts the Arbitrator's finding as to medical expenses awarded, but modifies/reverses the decision of the Arbitrator as to prospective medical care, herein denying any and all prospective medical testing and/or medical treatment (possible surgery).

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $832.67 per week for a period of 14-4/7 weeks, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $4,674.70 for medical expenses under §8(a) of the Act. The Commission further, herein, denies any and all prospective medical testing-(MRI, arthrogram) and any and all prospective medical treatment-(as to any possible surgery based on arthrogram).

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.

15IWCC0004

Bond for the 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: JAN 6 - 2015
o-11/6/14
DLG/jsf
045

David L. Gore

Stephen Mathis

Mario Basurto

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

MOYERS, JOSEPH
Employee/Petitioner

Case# **10WC042786**

10WC014758

ROCK RIVER DISPOSAL
Employer/Respondent

15IWCC0004

On 9/19/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.03% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2489 LAW OFFICES OF JIM BLACK & ASSOC
BRAD A REYNOLDS
308 W STATE ST SUITE 300
ROCKFORD, IL 61101

2027 WIEDNER & McAULIFFE LTD
JEFF SALISBURY
1639 N ALPINE RD SUITE 300
ROCKFORD, IL 61107

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
19(b)

15IWCC0004

Joseph Moyers
Employee/Petitioner

v.

Rock River Disposal
Employer/Respondent

Case # 10 WC 042786

Consolidated cases: 10 WC 14758

An *Application for Adjustment 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 **Rockford**, on **July 22, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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 _____

15IWCC0004

FINDINGS

On the date of accident, **March 12, 2010**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$64,954.76**; the average weekly wage was **$1,249.13**.

On the date of accident, Petitioner was **34** years of age, ***married*** with **0** dependent children.

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

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

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

ORDER

The Respondent shall pay Petitioner $4,674.70 for medical care and medication rendered and prescribed by Dr. Freedburg pursuant to 8a and 8.2 of the Act. Also pursuant to 8a and 8.2 of the Act the Arbitator awards future medical benefits as recommended by Dr. Freedburg,i.e. an MRI arthrogram and possible surgery based upon the arthtrogram.

The Arbitrator awards 14 5/7 weeks of TTD for the period March 17, 2010 through June 28, 2010 at a rate of $832.67 per week.

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

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

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

Carl Lee

Signature of Arbitrator

9/18/13

Date

ICArbDec19(b)

SEP 19 2013

IN AND BEFORE THE
ILLINOIS WORKERS' COMPENSATION COMMISSION

Joseph Moyers, Employee/Petitioner, v. Rock River Disposal, Employer/Respondent.	Case No. 10 WC 042786

DISPUTED ISSUES

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

Joseph Moyers worked for Rock River Disposal for nine years as a mechanic. Respondent operates a garbage hauling facility. Mr. Moyers testified that he repaired trucks belonging to the Respondent but did not do engine repairs. Petitioner testified that on March 12, 2010, he was called out to Mitchell Road on Highway 173 regarding a disabled recycle truck. Petitioner described the truck as manufactured by Volvo and it was in a series of Fleet vehicles in the 400's identifying it as one of the Respondent's recycle trucks.

Petitioner testified he drove the Respondent's service truck out to Mitchell Road and Highway 173. Petitioner's observations were of a recycling truck owned by the Respondent that was not running. The driver of the vehicle was Justin Wilkins. Petitioner inspected the fuel filter which revealed brass shavings. Petitioner was not able to get the recycle truck running. Petitioner testified he called to Mike Garrison (Supervisor) notifying him that the vehicle had to be towed. Petitioner then went to his service truck and got his tools. Using a creeper, he laid underneath the truck in order to remove the drive shaft. Petitioner removed the drive shaft so that the vehicle could be towed. The vehicle could not be towed unless the drive shaft was removed. Petitioner described that there were four bolts which had to be removed one at a time in order to remove the drive shaft.

Petitioner testified that as he removed the last bolt that the drive shaft skipped out of the U-joint landing on the Petitioner. Petitioner testified he guided the drive shaft with his right arm to the side so that it could be laid onto the ground. Petitioner testified the drive shaft weighed somewhere between 100-150 pounds. Petitioner further described that the drive shaft fell on him unexpectedly and that he caught it with his right arm and while doing so felt immediate pain in his right shoulder.

Petitioner testified that he radioed Mike Garrison at the terminal and reported that he had just injured his right shoulder. Petitioner then testified that he and the driver, Justin, carried the drive shaft to his service truck. Petitioner then drove back to the terminal where he dropped off Justin. According to the Petitioner, he completed his time logs for the day and then left the facility and drove directly to Brookside Immediate Care at the direction of his employer. Petitioner testified he was seen on the accident date at Brookside Immediate Care. Brookside Immediate Care records show Petitioner arrived at ( ). See PX 3. Upon arrival at Brookside, Petitioner testified that he reported injuring his right shoulder on the date he was seen while disabling a drive shaft from a recycle truck.

At trial, Petitioner testified that the nurse, who took his history, inquired as to whether he had experienced right shoulder symptoms prior to March 12, 2010. Petitioner testified that he responded to the nurse by stating he had, had some off and on shoulder pain in the past, but nothing like what he was experiencing on the day that he was seen on March 12, 2010. Petitioner testified that the occupational nurse asked him for a date where he had noted these prior symptoms. Petitioner responded that he did not recall a specific date and that there was no date that he could give her. According to the Petitioner's testimony, the nurse reported that she "had to have a date" and so she selected January 25, 2010. Petitioner's only comment to the nurse, at that time, was that the date should not be on a Sunday where he did not work.

Respondent disputes notice and accident. Respondent contends that the Petitioner's injury occurred on January 25, 2010 based upon the initial history recorded at Brookside Immediate Care. Nurse's notes from March 12, 2010 record the following history:

> "Right shoulder injury- taking drive shaft out of truck. Incident happened on January 25, 2010 and pain continues- pain number 8- NZ."

Doctor's history of the same date states treatment date as March 12, 2010. Date of injury listed is January 25, 2010. In history/physical, the following impression is recorded:

> "Chief complaint: right shoulder pain. HPI. Caucasian male here today who works for Rock River Disposal. According to the patient, he was working on a truck when he had a drive shaft slip causing most of the drive shaft weight to come down on his right upper extremity. Patient had some significant discomfort at the time of the injury, which he states was last month; however, it has gotten increasingly worse since that point in time and also he has had some decreased range of motion overall with the right upper extremity. The patient has been taking ibuprofen over the counter to help deal with his discomfort but is has been increasing and he has had problems sleeping. The patient has been performing his regular work duties but with a significant amount of pain. He denies any numbness or tingling. States most of the discomfort is located in the deep portion of his right shoulder. Denies any prior history of injury to his shoulder before. Past medical history: denied. Medications: none. Allergies: Keflex." PX 3.

Respondent argues if any injury occurred to the Petitioner that it occurred on January 25, 2010. Respondent then argues that its first notice of injury was on March 12, 2010 when the Petitioner was first seen at Brookside Immediate Care. Respondent argues that 6(c) of the act requires verbal or written notice of an injury within 45 days of its occurrence. Respondent argues that since March 12, 2010 (first date of notice alleged by the employer) was more than 45 days after January 25, 2010 that Petitioner failed to prove timely notice of a work injury and therefore, no compensation can be awarded.

Witness testimony at the time of hearing included in Respondent's Case-in-Chief was from Mike Garrison and Butch Taylor. In addition, there was substantial documentation and documentary evidence offered into the record which bears significance to the issue of accident and when the accident occurred. Mike Garrison testified in the Respondent's Case-in-Chief. Mr. Garrison worked for the Respondent for 12 years. At the time

of the hearing, Mr. Garrison was no longer employed by Rock River Disposal. He appeared pursuant to a subpoena.

In 2010, Mr. Garrison was a route supervisor whose primary responsibilities included getting out trucks and handling customer calls. Mr. Garrison testified that most of his work was performed in the field in a pick-up truck, but that his base was at the Rock River Disposal facility/ repair shop on South Main Street in Rockford, Illinois. Mr. Garrison testified that he was not Mr. Moyers' immediate supervisor. Butch Taylor was the Petitioner's immediate supervisor. However, Mr. Taylor was not working on March 12, 2010 and so Mr. Garrison was the Petitioner's acting supervisor on March 12, 2010. Mr. Garrison testified that on March 12, 2010, he was notified that Petitioner injured his shoulder while removing a drive shaft. However, Mr. Garrison testified that he could not recall if the Petitioner actually injured his right shoulder on March 12, 2010 or on another date. He could only recall speaking to the Petitioner at the shop and that the Petitioner had reported that he hurt his shoulder pulling out a drive shaft. Mr. Garrison testified that he instructed the Petitioner to go to the occupational clinic and that for work injuries, employees of the Respondent were sent to Brookside Immediate Care. Mr. Garrison testified that he did not recall any prior reported shoulder problems involving the Petitioner before the report that Petitioner injured his right shoulder that was received by Mr. Garrison on March 12, 2010. Mr. Garrison testified he also recalled speaking to the Respondent's Risk Management contact person on March 12, 2010 concerning Joseph Moyers. **During cross examination, Mr. Garrison was shown Petitioner's Exhibit No. 7. and Respondent's Exhibit No. 3. After review of the documents, Mr. Garrison testified that it appeared that Mr. Moyers' injury occurred on March 12, 2010.**

James "Butch" Taylor also testified in Respondent's Case-in-Chief. Mr. Taylor testified pursuant to a subpoena. He was employed by the Respondent beginning in April of 2008 and last worked for the Respondent in April of 2011. Mr. Taylor testified he was the supervisor over all mechanics, including the Petitioner, in March of 2010. Mr. Taylor testified that March 12, 2010 was a Friday. Mr. Taylor testified that he did not work

on Friday and that on that date Mr. Garrison was the acting supervisor over the drivers. Mr. Taylor testified his first day back to work after vacation was the following Monday on March 15, 2010. Mr. Taylor testified that early in the morning of March 15, 2010, Mr. Garrison told him that Joseph Moyers had reported injuring his shoulder the previous Friday and that he had been sent to Brookside Immediate Care. Mr. Taylor testified that in his absence, Mike Garrison filled out the first report of injury on March 12, 2010.

Mr. Taylor testified on March 15, 2010, he received a call from Karen Cox (Risk Management for the Respondent) and was notified that there was a discrepancy in the treating record as to when the accident occurred. Mr. Taylor spoke to Joseph Moyers either on March 15, 2010 or March 16, 2010 and received an explanation that the Petitioner injured his right shoulder while removing a drive shaft from a recycle truck. According to Mr. Taylor, the Petitioner initially told him the injury occurred in January of 2010, but the following day reported the accident as March 12, 2010. Mr. Taylor identified his 2010 journal at the time of the hearing. Mr. Taylor explained that he kept notes each day regarding work-related matters in 2010. Mr. Taylor confirmed his journal and the copies or excerpts of the journal marked as Respondent's Exhibits were true and accurate copies of the original and all in his handwriting. Mr. Taylor verified that he made journal entries on January 25, 2010, January 26, 2010, and on March 15, 2010. The journal showed Mr. Taylor was on vacation on March 12, 2010.

Mr. Taylor testified that there were two ways to disable a Volvo recycle truck so that it could be towed. Either the mechanic could disconnect the drive shaft, or the mechanic could pull the axel at the hub. Pulling the axel at the hub would not require the driver to be underneath the vehicle. Disconnecting the drive shaft would require the mechanic to be under the vehicle. Mr. Taylor testified that Joseph Moyers returned to work on June 28, 2010 after being cleared to return to work full-duty and upon providing a note to that effect to the Respondent. Mr. Taylor testified that he was not the author of Respondent's Exhibit No. 1; instead, that was authored by Mike Garrison. Mr. Taylor testified he did complete the accident report which was identified as

Respondent's Exhibit No. 2. Mr. Taylor testified in review of Respondent's Exhibit No. 3 that the entries made by the Petitioner would suggest that he continued working at the shop for the Respondent after the time entry identified from 11:00 a.m. to 12:30 p.m. However, Mr. Taylor testified he did not work on March 12, 2010 and had no personal knowledge of any work performed by the Petitioner on that date.

DOCUMENTARY EVIDENCE

Petitioner's Exhibit No. 7 was admitted into evidence without objection by the Respondent. Petitioner's Exhibit No. 7 was obtained in response to a valid subpoena from Maggio Truck Center. Witnesses for the Respondent and the Petitioner testified that Maggio Truck Center towed Fleet vehicles owned by the Respondent when they were disabled. Petitioner's Exhibit No. 7 is an invoice sent by Maggio Truck Center to Rock River Disposal. The date of the invoice is March 12, 2010. The description of services rendered was "Wrecker service to Highway 173 towed to International". The date of service was March 12, 2010. **The model was a 2000 Volvo Fleet #40141.** The amount of the bill was $375.00.

Respondent's Exhibit No. 3 was a two page exhibit which consisted of Petitioner's time sheets for January 25, 2010 and March 12, 2010. The Petitioner was identified by his work number (10071) on January 25, 2010 and by his name on March 12, 2010. The Petitioner testified at the time of trial that he completed, in his own handwriting, both time sheets for January 25, 2010 and March 12, 2010. Significantly, on January 25, 2010, there are no entries involving a description of work activities where the Petitioner was out on Highway 173. Furthermore, there are no descriptions of the work activity involving Petitioner removing or disabling a drive shaft so a Fleet vehicle could be towed. On March 12, 2010, the fourth entry under work to be done lists as follows:

"40141- 11:00 a.m.-12:30 p.m. Motor problems- towed to International."

Respondent's Exhibit No. 1 was Employers First Report of Injury or Illness, which was completed by Mike Garrison. The form was completed on March 15, 2010. Under "date and time of injury or exposure", there

are two accident dates listed: March 12, 2010 and January 25, 2010. Under "what task was the employee performing when the illness occurred?" it states "he was working on a truck, a drive shaft slipped and came down on right shoulder".

Respondent's Exhibit No. 2 was the accident/incident report completed by Butch Taylor. In the attachment to Respondent's Exhibit No. 2, Butch Taylor's notes state as follows: "**I did observe Moyers favoring or carrying his right arm 15 March 2010 early in the morning (first time I had ever observed this).**" In Respondent's Exhibit No. 2, it is reported that the subject Moyers states removing drive shaft on January 25, 2010 as the cause of his work injury.

Respondent's Exhibit No. 6 was copies of the calendar/ journal of Butch Taylor from January 25, 2010, January 26, 2010, March 12, 2010, March 15, 2010, and March 16, 2010. On January 25, 2010 and on January 26, 2010, there are no entries concerning Joseph Moyers report of a work injury or any information regarding Fleet #40141 being towed from Highway 173 by Maggio Truck Center to International. Mr. Taylor's March 15, 2010 journal entry noted, "#40141 12 March 2010 towed to International by Maggio out of fuel. Joe M. made service call". On the same date, an additional entry states, "Joe Moyers to Brookside March 12, 2010 for shoulder problem. January 25, 2010- no first report of injury. He had to tell physician some sort of a date".

After considering the testimony of all witnesses and the Petitioner, and after review of all of the documentary evidence, the Arbitrator finds the Petitioner sustained his burden of proving an accident arose out of and in the course of his employment on March 12, 2010 for the Respondent. All of the evidence save the history recorded in the medical records from Brookside Immediate Care on March 12, 2010 overwhelmingly suggests that the Petitioner sustained an accidental injury to his right shoulder on March 12, 2010. Petitioner testified that his injury occurred on March 12, 2010 not January 25, 2010. In examining the Petitioner's time sheet from March 12, 2010, it lists work described by Petitioner from 11:00 a.m. to 12:30 p.m. involving recycle truck **#40141** with explanation "Motor problems- towed to International". In comparing this exhibit to

Petitioner's Exhibit No. 7, which was the billing invoice from Maggio's, the same Fleet number is identified- **#40141** with explanation that wrecker service was provided to Mitchell Road and Highway 173. This matched identically with the Petitioner's testimony as to when and where the repair occurred. Respondent's Exhibit No. 6, which was supervisor Taylor's handwritten note, confirm on March 15, 2010 that #40141 was towed to International by Maggio's on March 12, 2010.

Petitioner's time sheet on January 25, 2010 lists no entries involving recycle truck #40141. None of the entries indicate that the Petitioner removed a drive shaft from a Fleet vehicle on that date. In Respondent's Exhibit No. 6, Butch Taylor's journal notes from January 25, 2010 and January 26, 2010 do not contain a report of injury from Joseph Moyers. These entries do not indicate anything about recycle truck Fleet #40141 having its drive shaft disabled or having to have been towed.

Witness testimony by Mike Garrison and Butch Taylor, who were called by the Respondent, is persuasive and supportive of a finding by the Arbitrator that the injury occurred on March 12, 2010. Mike Garrison was asked to review Petitioner's Exhibit No. 7 on cross examination. After review of Petitioner's Exhibit No. 7, Mr. Garrison testified that it was probably the case that Mr. Moyers injury (which he recalled was reported on March 12, 2010 to him as asking supervisor of the Petitioner) did take place on March 12, 2010. Butch Taylor, who was not present on March 12, 2010, made journal notes that he observed Mr. Moyers favoring his right arm for the *first time* when he returned to work the following Monday on March 15, 2010. Significantly, Mr. Taylor's notes indicate that he had never made this observation regarding the Petitioner prior to March 15, 2010 and that Mr. Taylor had *daily* contact with Mr. Moyers since 2008 until the time that the journal entry was made on March 15, 2010.

The Arbitrator is not persuaded that the accident occurred on January 25, 2010. The Arbitrator is mindful of Respondent's Exhibit No. 3. The Arbitrator does acknowledge that there are three entries listed by Mr. Moyer, which report to show that Mr. Moyers did work from 12:30 p.m. to 3:00 p.m. following the entry

described as "Motor problems- towed to International". This would appear inconsistent with Petitioner's testimony that he returned with the service truck and the driver to Rock River Disposal before driving to Brookside Immediate Care. During his testimony, the Petitioner testified that he did return to the South Main facility to return the service truck. Petitioner then testified that he filled out his time sheet for the day listing work he had *already done that day in the morning*, but reporting that he had completed the work after he stated he left for Brookside Immediate Care. The Arbitrator is satisfied with the Petitioner's testimony that he did the work listed on Respondent's Exhibit No. 3 on March 12, 2010, even if the times that he reported doing the work are not correct.

Respondent's strongest argument that the injury occurred on January 25, 2010 is the initial history recorded at Brookside Immediate Care. There it states that Petitioner's injury occurred on January 25, 2010 while removing a drive shaft. However, there is overwhelming evidence that the injury took place on March 12, 2010 rather than January 25, 2010 for the reasons identified above. In addition, the Arbitrator is persuaded by the Petitioner's explanation concerning the history. Petitioner specifically testified that he was asked by the nurse after he described injuring his arm on March 12, 2010 whether he had previous shoulder pain. Petitioner reports that he told the nurse that he had previous shoulder pain (nothing like on the date that he was seen) and she inquired about a date when the shoulder pain began. According to the Petitioner, he was not able to give the nurse a date, although she insisted that a date be identified and that she picked the date January 25, 2010. In review of the journal entries by the Petitioner's immediate supervisor, it is clear that the Petitioner gave the same history to his supervisor. On March 15, 2010, the journal entry from Supervisor Taylor states "January 25, 2010- no first report of injury- states **'he had to tell physician some sort of a date'**".

The Arbitrator finds there are valid reasons to doubt the accuracy of the history in the first medical history from Brookside on March 12, 2010. The Arbitrator reviewed the evidence deposition of Nurse Nancy Zunker. PX 5. When her deposition was given on October 25, 2012, Ms. Zunker testified

that she had no independent recollection of the events of March 12, 2010. PX 5; Deposition Transcript Pages 17, 18. Ms. Zunker testified that Petitioner was seen at 15:50 hours military time. PX 5; Deposition Transcript Pages 20, 21. Ms. Zunker testified that when an injured worker is sent by an employer to Brookside that there are communications that can take place between the facility and the representative of the employer after the patient is seen. PX 5; Deposition Transcript Pages 23, 24. Information that could be discussed between Brookside and the employer include history, diagnosis, and treatment plan. PX 5; Deposition Transcript Page 24.

On direct examination by counsel for the Respondent the following exchange took place:

Q. Now, as part of the general practice in seeing a patient for an occupational injury does the nurse take a history?
A. Yes. We take a brief history of what is going on. We don't go in the back-- see what is going on back-- if it's a recheck, we will. We will look at the paperwork and say, "Now, okay. You are here for this." But if it's a new injury, you know, we usually just blankly get the information from the patient, jot it down. Sometimes, I **usually say "Patient states."** That way the patient tells me exactly what is going on. PX 5; Deposition Transcript Page 9.

On cross examination when shown her handwritten notes of the history taken on March 12, 2010, the following exchange took place:

Q. There is a history that is recorded, and the initials are N.Z.; is that correct?
A. Yes.

Q. And N.Z. would be you, Nancy Zunker; is that right?
A. Yes.

Q. And, again, you recognize this as your own handwriting?
A. Yes.

Q. Now, is there a spot on this form where your history starts with the phrase "Patient states"?
A. No.

Q. But ordinarily that would be your practice, to take a history in that way based on your testimony earlier; is that correct?
A. Yes. PX 5; Deposition Transcript Pages 24, 25.

Here, Nurse Zunker did not record petitioner's history as she testified she ordinarily receives it from an injured worker. This calls into question the accuracy of the history contained in the medical record on March 12, 2010.

The Arbitrator also reviewed the Evidence Deposition of Dr. Ryan Phasouk contained in Petitioner's Exhibit No. 4. Dr. Phasouk acknowledged, on direct examination by counsel for the Respondent, that his portion of the history and office note dated March 12, 2010 *did not contain* a specific date of accident. PX 4; Deposition Transcript Pages 15, 16. Dr. Phasouk testified that generally, he goes **by what is reported by the nurse as the date of injury**. Dr. Phasouk goes with the date given by the nurse as reported in her history. PX 4; Deposition Transcript Pages 15, 16. Dr. Phasouk testified that Petitioner's office evaluation and results were faxed to the contact person listed for Rock River Disposal on the same date Petitioner was seen on March 12, 2010. PX 4; Deposition Transcript Pages 21-23.

Dr. Phasouk's own history was that the Petitioner had some significant discomfort at the time of the injury **"which he states was last month"**. PX 4; Deposition Transcript Page 27. Dr. Phasouk agreed that last month would be some date in *February*, rather than in *January* 2010. PX 4; Deposition Transcript Pages 27, 28. Dr. Phasouk admitted, on cross examination, that it would be fair to say that there was an inconsistency between what was recorded as stated by the patient when this particular injury with the drive shaft occurred and the actual date of injury. PX 4; Deposition Transcript Page 28. Dr. Phasouk testified that the Petitioner reported no past medical history that was relevant concerning his right shoulder. PX 4; Deposition Transcript Page 29. These inconsistencies lead the Arbitrator to conclude that the March 12, 2010 histories recorded by the occupational clinic's nurse and doctor are not accurate.

Clearly, the Petitioner gave a consistent history to the Respondent and all medical providers regarding the mechanism of injury. Petitioner always reported that he sustained injury to his right shoulder while removing a drive shaft. Petitioner's immediate supervisor testified that to disable a truck to be towed that this could be done by removing the drive shaft and that the mechanic would have to be underneath the truck in order to do it.

Other medical records created on or near the reported date of accident clearly identify the date of injury as March 12, 2010. When Petitioner was seen by Dr. Freedburg on March 31, 2010 at Suburban Orthopedics, the history was "34 year old right hand dominant male with complaints of right shoulder pain from an injury at work on March 12, 2010. Patient is a mechanic and was removing a drive shaft from a truck, was laying on his back taking out the bolts that were holding the shaft. When he loosened the last bolt, the shaft fell and he tried to catch it. Sharp pain shot through his shoulder in the front near the joint. States he felt a throbbing pain when he went back to his truck. As soon as he got back to the shop, he reported to the supervisor, went to the clinic". See PX 1. This history was taken less than three weeks after the injury and to a physician selected by the Petitioner, rather than the employer's occupational clinic where he was instructed to go. It is clear from Respondent's own exhibits that Respondent sought to "cash-in" an opportunity to deny the claim based on a lack of notice within 45 days, based on the doctor's evaluation from March 12, 2010. Both the nurse and Dr. Phasouk testified that the medical record would have been faxed to Rock River Disposal on March 12, 2010. Subsequent denials of the Workers' Compensation claim ensued immediately. However, the Arbitrator finds overwhelming evidence that Petitioner's injury involving removal of the drive shaft occurred on March 12, 2010, and is not persuaded that the history recorded by the occupational clinic on the same date is accurate.

D. What was the date of the accident? 15IWCC0004

For all the reasons identified above, the Arbitrator finds Petitioner's right shoulder injury occurred on March 12, 2010.

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

The Arbitrator finds that the Petitioner's injury involving the drive shaft occurred on March 12, 2010. Mike Garrison testified that he received a report of an injury by the Petitioner to his right shoulder on March 12, 2010. Mr. Moyers' immediate supervisor, Butch Taylor, received a similar report of work injury on March 15, 2010. Clearly, these two reports are well within 45 days as required by Section 6(c) of the Act. The Arbitrator does not find Petitioner's injury occurred on January 25, 2010 for the reasons stated above.

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

When seen on March 12, 2010 at Brookside Immediate Care, Petitioner's physical examination revealed a limited range of motion with abduction and significant pain with abduction against resistance at 20 degrees. PX 3. **Patient also had positive Hawkin's Test and Neer's Impingement Test.** He also had difficulty tracking his right hand behind his back. PX 3. X-rays taken on that date, of the right shoulder, were normal. The preliminary diagnosis was right shoulder strain. **Dr. Phasouk noted his index of suspicion, that the patient is quite high for rotator cuff tear; hence next week if the patient has not shown a significant improvement with treatment rendered today, we will order an MRI to evaluate the situation closely.** PX 3. Petitioner was placed on a work restriction on March 12, 2010 of no lifting over the right shoulder height with the right upper extremity. No lifting more than 25 pounds. Petitioner was rechecked on March 18, 2010 at Brookside Immediate Care. He reported pain level at 8 out of 10 in his right shoulder. PX 3. He remained on work restrictions of no lifting greater than 25 pounds and no reaching over shoulder height with his right arm. A right shoulder MRI was ordered on March 18, 2010. PX 3. There is a notation on March 19, 2010 that the right

shoulder MRI was denied by the Respondent. Petitioner did not appear for his follow-up visit scheduled on March 25, 2010. PX 3.

Petitioner was seen by Dr. Freedburg at Suburban Orthopedics on March 31, 2010. Pain symptoms were described as a 5 out of 10 in the right shoulder. Physical examination noted limited range of motion. Crepitus was noted with circumduction of the AC joint. X-rays were taken, which revealed type II acromion and minimal degenerative joint disease of the right shoulder. Preliminary diagnosis by Dr. Freedburg was right shoulder bicipital tendonitis, right shoulder bone contusion of the acromion and right shoulder sprain. PX 1. Significantly, MRI of the right shoulder dated March 25, 2010 **showed bone marrow edema** involving the acromion, **probably post-traumatic with bone bruising**. PX 1. Assessment was right shoulder sprain with acromion bone contusion. The plan was medications, physical therapy, and light-duty. Petitioner was to follow-up in three weeks. PX 1. Petitioner was rechecked on May 3, 2010 regarding his right shoulder. Pain was reported to be constant. The Petitioner was noted to be unable to raise his arm above his shoulder. Physical therapy was not started, although recommended. PX 1. Physical exam revealed tenderness over the biceps tendon and limited range of motion with the right shoulder. PX 1. Additional x-rays were taken on that date, which were normal. Conservative treatment continued to be recommended consisting of medications, physical therapy, injection, and light-duty. **Because of signs of rotator cuff pathology**, a subacromial cortisone injection was recommended and performed on that date. PX 1. Dr. Freedburg continued the Petitioner on light-duty work at that time. He was to follow-up in three weeks. PX 1.

When seen again on May 24, 2010, the Petitioner continued to report pain in the right arm. He continued to have pain when he raised his arm above shoulder height. It was reported that the Petitioner had started physical therapy, but this seemed to be aggravating the pain in his shoulder. PX 1. Physical examination continued to be the same as previous visits. Diagnosis included right shoulder bicipital tendonitis, right shoulder bone contusion of the acromion, and right shoulder sprain. Treatment options were discussed consisting of

conservative treatment with medications, physical therapy, injections, and light-duty. Petitioner remained on light-duty. PX 1. On July 15, 2010, Petitioner continued to report shoulder pain. It was noted at that time that the Petitioner had returned to work full-duty. Physical examination revealed limited range of motion of the right shoulder with crepitus. Treatment options including surgery were discussed. He was allowed to continue on full-duty and was to be seen in six weeks. PX 1.

In support of causation, the Petitioner offered the opinion of Dr. Freedburg. Dr. Freedburg opined that he treated the Petitioner from March 31, 2010 through July 15, 2010. Dr. Freedburg's diagnosis was right traumatic bicipital tendonitis with bone contusion to the acromion and rotator cuff tear. With regards to causation, Dr. Freedburg opined that there was a causal relationship between each diagnosis regarding the Petitioner's right shoulder and his March 12, 2010 work injury. Dr. Freedburg testified as follows:

> "I do believe that this is causally connected. He did have an injury. It seems to be bona fide. I do not have the work injury report, but based off of the history provided to be there is just no question that this was an injury sustained at work to an asymptomatic shoulder. As far as the MRI not showing rotator cuff tear, I am not clear if that is the case. An MRI arthrogram down the road would prove it. More importantly, he does have bicipital tendonitis and possibly a SLAP lesion that I think would probably be in need of surgical intervention". PX 2.

Dr. Freedburg testified that the Petitioner was in need of additional medical treatment including an MRI arthrogram and that he would likely require surgery which would probably be in the form of arthroscopic biceps tenodesis, evaluation of the rotator cuff for possible repair, and possible distal clavicle resection for impingement. PX 2. Dr. Freedburg testified that Petitioner was not at MMI as of the last time that he was seen on July 15, 2010. All of Dr. Freedburg's opinions were offered to a reasonable degree of medical and orthopedic certainty. PX 2.

Respondent offered the IME report of Dr. Stephen Weiss. Dr. Weiss received a history that Petitioner was supporting a drive shaft with his right hand while lying on his back under a truck on March 12, 2010. After the last bolt was removed, the drive shaft unexpectedly fell and struck his shoulder and forced his right arm into a fully externally rotated position producing immediate pain. Petitioner notified Respondent's IME examiner

that the injury occurred on March 12, 2010, despite the inconsistencies regarding the date in the initial record from Brookside Immediate Care. Dr. Weiss reviewed the medical records including the opinions of Dr. Freedburg and Dr. Freedburg's treating records. Dr. Weiss diagnosed the Petitioner with impingement syndrome of the right shoulder with resolved contusion of the right acromion. Upon physical exam, Dr. Weiss noted the patient had supraspinatus and infraspinatus atrophy of his right rotator cuff. Dr. Weiss further opined that the Petitioner would require surgical intervention to alleviate his right shoulder condition. With regards to causation, Dr. Weiss opined that the bony contusion seen on MRI could be related to an injury date of March 12, 2010. Dr. Weiss opined that the traumatic event, if it occurred as described by the Petitioner, could have produced a contusion to the shoulder, which has resolved. Dr. Weiss noted his findings of rotator cuff atrophy were more likely related to a preexisting degenerative process rather than a traumatic incident as described by the Petitioner.

After considering the opinions of the experts, the Arbitrator finds persuasive the opinion of Dr. Freedburg and adopts the opinion of Dr. Freedburg over the opinion of Dr. Weiss, concerning causation. Here there is no evidence that the Petitioner had any right shoulder pathology before March 12, 2010. MRI shows bony contusion to the acromion, which was post-traumatic. This is most consistent with the 100 pound drive shaft falling onto the Petitioner's right arm and his attempts to hold the drive shaft up and then lower it carefully to the ground. The mechanism of injury is consistent with bicipital tendonitis, bony contusion to the acromion, impingement, and rotator cuff pathology.

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?

Having found Petitioner sustained his burden of proving notice, accident, and causal connection, the Arbitrator finds that the Petitioner's medical treatment was reasonable and necessary and casually related to the

March 12, 2010 injury to his right shoulder. Respondent is ordered to pay the medical bills contained in Petitioner's Exhibit No. 6, pursuant to the Illinois Fee Schedule.

K. Is Petitioner entitled to any prospective medical care?

The Arbitrator notes both Dr. Weiss and Dr. Freedburg did not place the Petitioner at MMI regarding his right shoulder. Dr. Weiss found positive evidence of rotator cuff atrophy and indicated right shoulder surgery was necessary to alleviate Petitioner's condition of ill-being. Dr. Freedburg testified that the Petitioner required an MRI arthrogram in order to further define his shoulder pathology. Dr. Freedburg noted, more importantly, that the Petitioner had bicipital tendonitis and a possible SLAP lesion, which would require surgical treatment even if the rotator cuff was not torn. In addition to an arthroscopic biceps tenodesis, Dr. Freedburg was recommending arthroscopic evaluation of the rotator cuff after the MRI arthrogram, as well as possible distal clavicle resection. The Arbitrator finds the Petitioner is entitled to the MRI arthrogram and shoulder surgery to be performed, based on the results of the arthrogram as recommended by Dr. Freedburg.

L. What temporary benefits are in dispute?

☐ TPD ☐ Maintenance ■ TTD

Initially, the Petitioner was placed on light-duty by Brookside Immediate Care. He remained on light-duty with that facility until he came under the care of Dr. Freedburg on March 31, 2010. Petitioner continued on light-duty work restrictions until his return to full employment on June 29, 2010.

The Arbitrator reviewed Respondent's surveillance contained in RX 12. The surveillance was taken during the time period where Petitioner claimed TTD. However, review of the surveillance does not demonstrate that the Petitioner was working for Respondent or any other employer. None of the activities

shown in surveillance were outside restrictions ordered by the physicians who had him on light-duty rather than off work status completely.

Mr. Taylor testified that the Respondent had no light-duty work for the Petitioner during the time that he was on light-duty. Pursuant to *Interstate Scaffolding v. The Industrial Commission*, Petitioner is entitled to TTD benefits during the time he was on light-duty where Respondent had no light-duty work for him, as he has not achieved MMI during that time period for his work injury.

The Arbitrator finds that the Petitioner is entitled to an award of TTD benefits for the period March 17, 2010 through June 28, 2010 or 14 and 5/7 weeks at the TTD rate of $832.67 per week. From March 12, 2010 through June 28, 2010, Petitioner remained on light-duty restrictions under the care of his physicians.

N. Is Respondent due any credit?

Arbitrator's Exhibit No. 1 is the parties' Stipulation Sheet. The parties stipulated the Respondent is entitled no credit under 8(j). Furthermore, the Respondent has paid no TTD benefits nor any medical bills. Therefore, Respondent is not entitled to any credit.

Date

Arbitrator Edward Lee

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

Nadine Killensworth,
Petitioner,
vs.

NO: 12WC 2158

Superior Air Ground Ambulance,
Respondent,

15IWCC0005

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 20, 2014, is hereby affirmed and adopted.

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

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

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

DATED: JAN 7 - 2015

Charles J. DeVriendt

Daniel R. Donohoo

Ruth W. White

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CJD/jrc
049

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

KILLENSWORTH, NADINE
Employee/Petitioner

Case# **12WC002158**

SUPERIOR AIR GROUND AMBULANCE
Employer/Respondent

15IWCC0005

On 2/20/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.07% 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:

2573 MARTAY LAW OFFICE
DAVID W MARTAY
134 N LASALLE ST 9TH FL
CHICAGO, IL 60602

0075 POWER & CRONIN LTD
BRIAN A RUDD
300 COMMERCE DR SUITE 300
OAKBROOK, IL 60523

15IWCC0005 15IWCC0005

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)

Case # 12 WC 02158

Consolidated cases: ____

Nadine Killensworth
Employee/Petitioner

v.

Superior Air Ground Ambulance
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 **Svetlana Kelmanson**, Arbitrator of the Commission, in the city of **Chicago**, on **January 13, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **5/13/2011**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

ORDER

No compensation is awarded. Petitioner failed to prove the work accident on May 13, 2011, caused more than a brief flare-up of her preexisting low back condition.

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

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

Signature of Arbitrator

2/19/2014
Date

ICArbDec19(b)

FEB 20 2014

FINDINGS OF FACT AND CONCLUSIONS OF LAW

On January 23, 2012, Petitioner filed an application for adjustment of claim, alleging that on May 13, 2011, she injured her low back while carrying a patient.

Petitioner testified that she worked as an emergency medical technician (EMT) for Respondent since 2008. On May 13, 2011, Petitioner felt pain in her low back while lifting a patient onto a bed. Petitioner described the pain as a "going out feeling." Later in the day, Petitioner sought treatment at Elmhurst Memorial Occupational Health Services (Elmhurst Occupational Health).

The medical records from Elmhurst Occupational Health show that on May 13, 2011, Petitioner complained of sharp low back pain after moving a patient from a stretcher to a bed, relating that she had similar pain a month earlier, but did not report an injury. On physical examination, Petitioner complained of tenderness to palpation over L4-S1 and pain with range of motion testing. Straight leg raise test was negative. X-rays of the lumbar spine were normal. The staff diagnosed lumbar strain/sprain, prescribed Naprosyn, and released Petitioner to return to work on restricted duty. On May 16, 2011, Petitioner followed up at Elmhurst Occupational Health, complaining of soreness in the low back without stiffness. Physical examination was within normal limits. The staff released Petitioner to return to work full duty and discharged her from care.

Petitioner testified that for the next three months she worked full duty as an EMT, a heavy duty job. During that time period she called in sick on two occasions, but did not treat for back pain. On August 24, 2011, Petitioner saw her primary care physician, Dr. Henning, complaining of back pain. Petitioner testified that she suffered from intermittent back pain between May 16, 2011, and August 24, 2011, and recalled a sneezing incident sometime in July of 2011 that triggered the pain, prompting her to see Dr. Henning.

The medical records from Dr. Henning show that on August 24, 2011, Petitioner complained of back pain "for past 6 years since 2005 when [she] began working as EMT and having to occasionally lift [patients]." Petitioner reported "intermittent episodes of severe pain occurring apprx once per month which make it difficult for her to work." Petitioner also reported occasional episodes of radiation of pain down the left leg and that she had undergone X-rays in "1/11," taken Vicodin, Naproxen and Flexeril "in the past," and used a back brace at work. The clinical note does not mention a work accident in May of 2011. Rather, Petitioner asked Dr. Henning to complete Family and Medical Leave Act (FMLA) paperwork. Physical examination was unremarkable. Dr. Henning ordered an MRI and prescribed physical therapy. The MRI, performed August 31, 2011, showed multilevel degenerative changes, with a central disc extrusion and mild foraminal stenosis at L4-L5 and a central/left paracentral protrusion with mild to moderate foraminal stenosis at L5-S1.

During her testimony, Petitioner disagreed with the accuracy of Dr. Henning's clinical note. Petitioner denied having low back problems before May 13, 2011, except for a low back strain in 2005, from which she had fully recovered that year. Further, Petitioner introduced into evidence a letter from Dr. Henning dated July 5, 2012, stating:

> "I am writing on behalf of [Petitioner] to state that the back pain incident that she had in 2005 was different from her more recent back pain symptoms she experienced after her injury in 2011."

Petitioner admitted that Dr. Henning wrote the letter at her request. Petitioner also admitted asking Dr. Henning to complete FMLA paperwork on August 24, 2011. Respondent introduced into evidence the FMLA paperwork, showing that Petitioner applied for intermittent leave of one to two days a month "per event." In support of Petitioner's FMLA application, Dr. Henning stated that Petitioner might be unable to lift greater than 20 pounds at certain times or perform her lifting duties during flare-ups; further stating: "Pt has intermittent lower back pain which limits her mobility and ability to perform lifting maneuvers. She has a back brace and medication to help with symptoms and I have referred her for physical therapy."

Physical therapy records from AthletiCo show that on August 31, 2011, Petitioner underwent an initial physical therapy evaluation. The physical therapist recorded the following history:

> "[The patient] has had low back pain on and off for several years within episodic pattern. Her symptoms have been worse in the last 6 to 8 months secondary to an incident during which she was lifting a patient up the stairs and getting him into bed awkwardly while at work as an EMT. She experienced an exacerbation of symptoms a few days ago when she sneezed and felt immediate seizing up of her low back. Her symptoms were 10/10 on Saturday, 4/10 on average and at best currently. Prior to this last exacerbation a few days ago, she had moments without pain."

On physical examination, Petitioner complained of tenderness to palpation and pain with range of motion testing. The physical therapist was unable to perform strength testing secondary to complaints of pain. The physical therapist concluded that Petitioner was unable to work as an EMT "secondary to pain with standing, lifting, pushing, and pulling required by work. Patient has increased pain with standing for prolonged periods of time, forward bending, and driving several hours." Petitioner attended physical therapy on August 31, 2011, and September 2, 2011. On September 2, 2011, Petitioner exhibited an improved pattern of movement with decreased pain behaviors, reporting that she was able to work the day before. On September 7, 2011, Petitioner cancelled her physical therapy session "due to not having money for transportation." Petitioner then failed to show for her scheduled appointments on September 9, 2011, and September 14, 2011. Subsequently, Petitioner asked to be discharged from physical therapy "secondary to financial concerns."

Petitioner testified that for the next almost nine months she did not seek further treatment for low back pain and continued to work as an EMT, although she continued to suffer from back pain. On May 23, 2012, Petitioner consulted Dr. Slack, a spine surgeon.

The medical records from Dr. Slack show that on May 23, 2012, Petitioner complained of persistent low back pain, which she attributed to the work accident on May 13, 2011. Petitioner

stated the pain affected her ability to perform her job duties as an EMT and denied "any prior history of similar symptoms in the past." On physical examination, Petitioner ambulated with a slow, deliberate gait and complained of discomfort and pain with range of motion testing. She reported low back tightness with supine straight leg raise test at 60 degrees. However, seated straight leg raise test was negative. Dr. Slack reviewed the MRI from August 31, 2011, and recommended against surgery. He prescribed physical therapy and medication, and restricted Petitioner to sedentary duty. Petitioner underwent physical therapy at AthletiCo from June 26, 2012, through September 10, 2012, reporting slow improvement and intermittent flare-ups of symptoms. At the time of her discharge, Petitioner stated she was ready to resume her normal activities, including sports. A functional capacity evaluation, ordered by Dr. Slack and performed on September 17, 2012, showed Petitioner could work at the medium physical demand level, whereas her job as an EMT was at the heavy physical demand level. The physical therapist noted inconsistent effort, however. On September 26, 2012, Dr. Slack ordered another functional capacity evaluation at a different facility. The second functional capacity evaluation, performed October 3, 2012, also placed Petitioner at the medium physical demand level, noting that she consistently struggled with lifting and carrying loads exceeding 20 to 30 pounds. On November 7, 2012, Petitioner followed up with Dr. Slack and complained of low back pain without radiating symptoms. Physical examination showed only slight improvement compared to the initial evaluation on May 23, 2012. Dr. Slack declared Petitioner at maximum medical improvement and restricted her from lifting more than 20 to 30 pounds.

On August 8, 2012, Dr. Levin, a spine surgeon, examined Petitioner at Respondent's request. Petitioner gave a history of back injury in 2005, which she described as a pulled muscle that healed within three months, and denied any other symptoms or problems with her low back until the work accident on May 13, 2011. Petitioner also reported a sneezing episode in August of 2011 and possibly one in July of 2011 that caused her low back to "lock up." Petitioner further told Dr. Levin she had no treatment for her low back condition between September of 2011 and May of 2012, and that her attorney had referred her to Dr. Slack. In terms of her current symptoms, Petitioner complained of low back pain and stiffness, which significantly limited her activities of daily living. Physical examination findings were similar to those noted by Dr. Slack. Dr. Levin reserved his opinions until he had the opportunity to review the MRI study. On October 2, 2012, Dr. Levin issued an addendum report after reviewing the medical records from Elmhurst Occupational Health, Dr. Henning and Dr. Slack, and the MRI study. Dr. Levin opined that Petitioner sustained a mild lumbar myofascial strain on May 13, 2011, which resolved by May 17, 2011.

Dr. Slack testified via evidence deposition on January 21, 2013, that Petitioner's low back derangement at L4-L5 and L5-S1 was causally connected to the work accident on May 13, 2011. Dr. Slack explained that he based his opinion on Petitioner's history; specifically "that she had denied problems prior to that time and stated that she started having difficulty with the lifting incident on May of 2011." Dr. Slack affirmed that Petitioner would not be able to return to her job duties as an EMT. On cross-examination, Dr. Slack reviewed the medical records from Dr. Henning, noting a history of preexisting low back pain and that Petitioner's physical examination on August 24, 2011, was normal. Dr. Slack stated that he "would not base [his] opinion on that piece of paper" because Dr. Henning was not an occupational medicine specialist or an orthopedic surgeon.

Dr. Levin opined in his evidence deposition taken July 9, 2013, that Petitioner suffered from chronic low back pain since 2005. Dr. Levin further opined the work accident on May 13, 2011, caused a mild lumbar myofascial strain or flare-up, which resolved by May 16, 2011.

Petitioner testified that she continues to suffer from back pain, although it has improved with physical therapy. She feels low back pain with physical activity and upper back pain when she compensates for low back pain. There are times she feels she might not be able to walk because of the pain. She takes over-the-counter pain medications and uses a heating pad approximately four times a week to help alleviate the pain.

Petitioner further testified that she has not worked since November 7, 2012. Petitioner stated that she has looked for work at various retail stores and online through careerbuilder.com. Petitioner maintained she has applied for at least 100 office type jobs through careerbuilder.com, but did not introduce into evidence any job search records, explaining that she could not find the record of her job search on her careerbuilder.com account. So far she has not received any job offers and would like vocational assistance from Respondent. On cross-examination, Petitioner testified she had no documentation of any of her job search. With regard to retail jobs, she recalled applying in person at Walgreen's, Aldi's and Bath & Body Works. She also recalled being interviewed for position in customer service and sales with AT&T, but not getting the job.

On cross-examination, Petitioner was questioned about Dr. Henning's mentioning her taking Vicodin for the pain and not attributing the pain to the work accident. Petitioner admitted taking Vicodin, explaining that she had some leftover Vicodin, which had been prescribed by Elmhurst Occupational Health. When Respondent pointed out the medical records from Elmhurst Occupational Health showed no prescription for Vicodin, Petitioner stated she did not know who prescribed Vicodin.

Petitioner further testified on cross-examination that in mid-June of 2012, she experienced a flare up of low back pain with radiation to the right leg. Petitioner variously testified she had discomfort from just sitting and could not walk to the bus stop without being in pain and that she continued to work as an EMT. Petitioner admitted going on a camping trip on June 9, 2012. She also admitted helping her boyfriend pack for the camping trip, carrying a rolled piece of carpet over her shoulder, and floating in an inner tube down the river.

Respondent introduced into evidence photographs of the camping trip, showing Petitioner participating in camping activities, seemingly pain-free. Respondent also introduced into evidence a surveillance video of Petitioner packing a car for the camping trip, which showed her moving in a slow, guarded manner.

In support of the Arbitrator's decision regarding (F), is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds as follows:

Petitioner claims a specific accident, not repetitive trauma to her low back. Petitioner is *not* claiming the years of working as an EMT caused or aggravated her low back problems. Rather, Petitioner claims her low back problems stem from the work accident on May 13, 2011.

The Arbitrator notes Petitioner's inconsistent and evasive testimony during the trial. Petitioner's demeanor during the trial also suggested lack of credibility. Turning to the medical records in evidence, the records from Elmhurst Occupational Health show that on May 13, 2011, Petitioner complained of sharp low back pain after moving a patient from a stretcher to a bed, relating that she had similar pain a month earlier, but did not report an injury. On physical examination, Petitioner complained of tenderness to palpation over L4-S1 and pain with range of motion testing. Straight leg raise test was negative. X-rays of the lumbar spine were normal. The staff diagnosed lumbar strain/sprain, prescribed Naprosyn, and released Petitioner to return to work on restricted duty. On May 16, 2011, Petitioner followed up at Elmhurst Occupational Health, complaining of soreness in the low back without stiffness. Physical examination was within normal limits. The staff released Petitioner to return to work full duty and discharged her from care. Petitioner testified that for the next three months she worked full duty as an EMT, a heavy duty job.

The medical records from Dr. Henning and AthletiCo note a history of preexisting low back problems, which made it difficult for Petitioner to work as an EMT. On August 24, 2011, Petitioner reported to Dr. Henning occasional episodes of radiation of pain down the left leg and that she had undergone X-rays in "1/11," taken Vicodin, Naproxen and Flexeril "in the past," and used a back brace at work. During the visit on August 24, 2011, when Dr. Henning completed Petitioner's FMLA paperwork, Petitioner did not allude to the work accident on May 13, 2011, and her physical examination was normal. At that time, Petitioner had been back to work full duty as an EMT for more than three months. In support of Petitioner's FMLA application, Dr. Henning stated that Petitioner might be unable to lift greater than 20 pounds at certain times or perform her lifting duties during flare-ups. After the visit on August 24, 2011, Petitioner continued to work as an EMT until consulting Dr. Slack on May 23, 2012.

Having carefully considered the entire record, the Arbitrator finds that Petitioner failed to prove the work accident on May 13, 2011, caused more than a brief flare-up of her preexisting low back condition. The Arbitrator gives greater weight to the opinion of Dr. Levin because it is based on the same medical records that were introduced into evidence. Dr. Slack, on the other hand, based his opinion on the history Petitioner provided to him—denying prior low back problems and attributing her low back complaints to the work accident in May of 2011.

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

Petitioner does not claim any unpaid medical bills from Elmhurst Occupational Health. The Arbitrator finds the medical bills Petitioner claims are unrelated to the work accident. Accordingly, no medical bills are awarded.

In support of the Arbitrator's decision regarding (K), is Petitioner entitled to any prospective medical care, the Arbitrator finds as follows:

Having found that Petitioner's current low back condition is not causally connected to the work accident, the Arbitrator awards no prospective medical care.

In support of the Arbitrator's decision regarding (L), what temporary benefits are in dispute, the Arbitrator finds as follows:

The Arbitrator finds the periods of temporary total disability and maintenance benefits Petitioner claims are not causally connected to the work accident. Petitioner does not claim temporary total disability benefits from May 14, 2011, through May 16, 2011. The Arbitrator notes that period of temporary total disability is only three days, and as such is not compensable under the Workers' Compensation Act.

In support of the Arbitrator's decision regarding (O), is Petitioner entitled to vocational rehabilitation, the Arbitrator finds as follows:

Having found that Petitioner's current low back condition is not causally connected to the work accident, the Arbitrator awards no vocational rehabilitation benefits.

STATE OF ILLINOIS)
) SS.
COUNTY OF McCLEAN)

☐ 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

CHAD TRANCHANT,

15IWCC0006

Petitioner,

vs.

NO: 12 WC 27179

STATE OF ILLINOIS – PONTIAC CORRECTIONAL CENTER,

Respondent.

DECISION AND OPINION ON REVIEW

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

Petitioner was a Correctional Officer at Respondent facility. On July 13, 2012, he was involved in an altercation with an inmate. Petitioner suffered injuries to his elbow, shoulder, low back and coccyx. The medical records showed that he suffered left shoulder sprain/separation, low level degenerative changes of the lumbar spine with tiny left paracentral disc bulge at L4-5 and right paracentral disc bulge at L5-S1 with no bony fracture, a coccyx fracture, and right elbow epicondylitis during work hardening.

The medical records also reveal that by July 30, 2012, Petitioner told Dr. Newcomer that his shoulder was "doing much, much better" but his tailbone was still sore and still bothered him with prolonged sitting. By September 7, 2012, Dr. Newcomer noted Petitioner's shoulder was "fantastic" and he was at maximum medical improvement. On October 29, 2012, Petitioner reported in physical therapy that his shoulder was not bothering him much at all, but his tailbone still wakes him and it is sore to sit. His back gets stiff but is not painful. On May 30, 2013, Petitioner reported he was "feeling really good now" though he still had pain at the tailbone. He believed he could return to work at full duty. Dr. Carmichael released him to work without restrictions and from further treatment.

Petitioner testified that his tailbone is not what is was before and he did "know if it ever will be." He has pain every day. Just about everything he does hurts his tailbone. He has kept up with his home exercise program for his tailbone, as well as all other parts of his body that were injured. However, he has not sought treatment since May of 2013.

Petitioner further testified he did not have pain in his left shoulder as he sat during arbitration. However, if he is overdoing workouts or lifting heavy weights he will "feel it the next day." The pain limits him "from doing things just as easy as pull ups;" any activity causes pain in his shoulder. His "back is nothing like it used to be." Numerous activities including running a long time, rowing, and softball hurt his back. Petitioner still experiences symptoms of right elbow epicondylitis that he suffered in work hardening. Playing softball, overdoing activities, and continuously turning keys hurt his elbow. He takes Ibuprofen and an anti-inflammatory prescribed by Dr. Newcomer.

Petitioner transferred from Pontiac Correctional Center, a maximum security prison, to Danville Correctional Center, a medium security prison about six to seven months prior to arbitration. His duties are almost the same at the new prison, but the inmates are a lot less violent; he does not have to worry about getting into a fight with an inmate every day. Petitioner testified his transfer was not the result of his work injuries. Petitioner notices his various symptoms every time he has to move property, pick anything up, or "do anything continuously with keys." He also has to travel a lot more now transporting inmates in a van. Sitting in the van seat for hours is very painful to his tailbone and back. He does not feel much pain in his left shoulder unless he is lifting overhead. Petitioner also testified he takes over-the-counter medication almost every day. He only takes the prescription medication when his elbow hurts. He understands that it can take up to 5-10 years for the coccyx to completely heal and he hopes it does not hurt for the rest of his life.

The Arbitrator awarded Petitioner 10% loss of the use of the right arm for the lateral epicondylitis and 25% loss of the person-as-a-whole. The person-as-a-whole award was appropriated at 7.5% for the left shoulder sprain/separation, 7.5% for the coccyx fracture, and 10% for the lumbar spine. The Arbitrator noted that Petitioner was 26 years old and would have to live with his disability for a longer period of time than an older worker; his work was physically demanding and would affect him to a greater degree than a worker in a less strenuous job; and Petitioner "credibly testified" to current complaints of his shoulder, occasional residual right elbow symptoms, and low back and coccyx pain.

The Commission acknowledges that Petitioner had to have extensive physical therapy/work hardening and was not able to return to work for about 10½ months. However, the length of therapy and convalescence was largely based on the physical nature of Petitioner's job as Correctional Officer and possible danger to his person if he returned to that position in a physically compromised condition. The Commission notes that there was no surgery performed and Petitioner testified that he still works in a highly physically demanding and engages in what appears to be strenuous physical workouts. The fact that is still able to engage in such activities and only takes over-the-counter medication "almost every day," suggests that he is not permanently disabled to the degree of 10% of the right arm and 25% of the person-as-a-whole.

In addition, Petitioner testified to only some shoulder pain with overhead activities and when he overdid physical activity and that his elbow only really bothered him when he engaged in heavy lifting, continuous key turning, and playing softball. The herniated discs were characterized as "tiny" and there was no treatment except for injections and physical therapy. According to the medical record and Petitioner's testimony, it appears that Petitioner's coccyx injury is currently the most problematic condition of ill being from which Petitioner suffers.

Based on the entire records before us, the Commission finds the Arbitrator's permanent partial disability award is excessive. Accordingly, the Commission reduces the award to the loss of 15% of the person-as-a-whole apportioned at 7.5% for the coccyx condition, 5% for the lumbar spine condition, and 2.5% for the shoulder condition. The Commission also reduces the award for the epicondylitis to 7.5% loss of use of the right arm, resulting in a total permanent partial disability award of 93.975 weeks.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $547.89 per week for a period of 75 weeks, as provided in §8(d)(2) of the Act, for the reason that the injuries sustained caused the loss of 15% of the use of the person-as-a-whole (apportioned at 7.5% for the fractured coccyx, 5% for the lumbar spine condition, and 2.5% of the left shoulder condition).

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $547.89 per week for a period of 18.975 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the loss of 7.5% of the use of the right arm.

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

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

DATED: JAN 8 - 2015

Ruth W. White

Daniel R. Donohoo

Charles J. DeVriendt

RWW/dw
O-12/2/14
46

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

TRANCHANT, CHAD
Employee/Petitioner

Case# **12WC027179**

ST OF IL PONTIAC CORRECTIONAL
Employer/Respondent

15IWCC0006

On 4/7/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.06% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0190 LAW OFFICES OF PETER F FERRACUTI
THOMAS M STROW
110 E MAIN ST
OTTAWA, IL 61350

0502 ST EMPLOYMENT RETIREMENT SYSTEMS
2101 S VETERANS PARKWAY*
PO BOX 19255
SPRINGFIELD, IL 62794-9255

5116 ASSISTANT ATTORNEY GENERAL
GABRIEL CASEY
500 S SECOND ST
SPRINGFIELD, IL 62706

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

1350 CENTRAL MGMT SERVICES RISK MGMT
WORKERS' COMPENSATION CLAIMS
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

APR 7 2014

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

STATE OF ILLINOIS)
)SS.
COUNTY OF McLean)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

15IWCC0006

Chad Tranchant
Employee/Petitioner

v.

State of Illinois Pontiac Correctional
Employer/Respondent

Case # 12 WC 27179

Consolidated cases: N/A

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gregory Dollison**, Arbitrator of the Commission, in the city of **Bloomington, Illinois**, on **February 26, 2014**. By stipulation, the parties agree:

On the date of accident, **July 13, 2012**, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $**47,483.80**, and the average weekly wage was $**913.15**.

At the time of injury, Petitioner was **26** years of age, ***single*** with **0** children under 18.

Necessary medical services and temporary compensation benefits have been provided by Respondent. Respondent has stipulated to payment of any unpaid and related charges as outlined in Petitioner's Exhibit #1.

Petitioner was temporary and totally disabled between July 14, 2012 through May 30, 2013, or 45-6/7 weeks, and was paid full service-connected leave benefits during that period.

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

15IWCC0006

ORDER

Respondent shall pay Petitioner the sum of $547.89/week for a further period of 125 weeks, as provided in Section 8(d)(2) of the Act, because the injuries sustained caused the permanent partial disability of said Petitioner to the extent of 25% person-as-a-whole (7-1/2% for his fractured coccyx; 7-1/2% for the left shoulder AC joint sprain and grade-1 shoulder separation; and 10% for two herniated disks).

Respondent shall pay Petitioner the sum of $547.89/week for a further period of 25.3 weeks, as provided in Section 8(e) of the Act, because the injuries sustained caused 10% loss of use of Petitioner's right arm thereof.

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

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

Signature of Arbitrator

4/4/14
Date

ICArbDecN&E p.2

APR 7 - 2014

STATEMENT OF FACTS

Petitioner, Chad Tranchant, testified that he became employed by Respondent, State of Illinois Pontiac Correctional Center, on August 18, 2009. He testified that he was employed as a correctional officer, and that his duties included maintaining security and control of the inmates.

Petitioner testified that on Friday, July 13, 2012, while undertaking his regular duties at the facility, he was confronted by an inmate who was found to have contraband. Petitioner further testified that this particular inmate stood over 6 feet tall and weighed roughly 300 pounds, and had recently been transferred to the facility due to an assault on another individual. Petitioner testified that this inmate was highly agitated and noncompliant. Petitioner testified that the inmate assaulted him while he was attempting to execute his orders. Petitioner further testified that the inmate struck him numerous times about the head and upper body before Petitioner was able to wrestle the inmate to the ground. Petitioner testified that the inmate landed on him and then continued to strike and kick him while on the ground. Petitioner testified that this entire altercation probably took 3-4 minutes before help arrived and the inmate was secured.

Petitioner testified that he suffered numerous injuries as a direct result of altercation at work, for which he sought medical attention immediately after the altercation ended. Petitioner testified at trial that he never had any issues with his tailbone, left shoulder, lumbar, or right elbow prior to the accident.

Medical records from Dr. Lacie Shanks, who saw Petitioner the same day as the accident, indicate that Petitioner had complaints of pain in multiple areas: including his left shoulder, low back, right lower abdomen, and buttock. (PX5, at 34) X-ray taken of the buttock area showed possible coccygeal fracture. (PX5, at 35) Petitioner was diagnosed with a tailbone injury, left shoulder contusion, abdominal pain, and a low back strain. (PX5, at 36) Petitioner was advised to rest and use ice/heat packs, given pain medication, told to use a donut pillow while sitting, and ordered to do a follow up his primary care physician within a week. (PX5, at 36)

On July 16, 2012, Petitioner presented to Dr. Joseph Newcomer at McLean County Orthopedics. Dr. Newcomer, after an examination and obtaining addition x-rays, diagnosed Petitioner with: 1) left shoulder AC joint sprain and grade 1 separation; 2) left low back pain and spasm; 3) low back SI join strain; and 4) coccyx fracture. It was recommended that Petitioner undergo physical therapy for the pain and inflammatory reduction modalities for the shoulder and low back. (PX3, at 12)

Petitioner followed up with Dr. Newcomer on July 30, 2012. At that time Dr. Newcomer noted Petitioner returned following a coccyx fracture and shoulder separation. Dr. Newcomer noted Petitioner's shoulder was improving, but the tailbone was still sore and still bothered Petitioner when he sat for prolonged periods of time. (PX3, at 13)

On August 13, 2012, Petitioner returned to Dr. Newcomer for a progress check. Dr. Newcomer indicated that Petitioner had been doing physical therapy, rehabbing the lower extremity, and recovering from a coccyx fracture. At that time Petitioner reported that the pain in his tailbone had improved, but he was still tender to palpation. Petitioner also reported an uncomfortable popping sensation over the AC join of the left shoulder. Dr. Newcomer recommended addition physical therapy with functional strength and condition exercises, and a follow-up in three weeks. (PX3, at 14)

Petitioner followed up with Dr. Newcomer on September 7, 2012. At this time, Dr. Newcomer noted that Petitioner had reached MMI on his shoulder. Regarding his coccyx fracture, an additional x-ray was done which showed it to be slightly displaced. Dr. Newcomer noted point tenderness to palpation in the same region

as the fracture with pain at 4/5 at its worst and 3 to 4 when Petitioner was sleeping and sitting. Dr. Newcomer was concerned that Petitioner could have a slightly malangulated coccyx, but indicated that he wanted to give it another four weeks to see if the symptoms would abate. (PX3, at 15)

Dr. Newcomer saw Petitioner again on September 24, 2012. A CT scan of his coccyx and sacrum had been done which showed a healed fracture, but one that had healed in a flexed position. Dr. Newcomer noted that he believed that most of the symptomatology at that point was SI joint related, and also noted that he believed there was enough force with the trauma to have thrown his sacroiliac joint out of whack. Dr. Newcomer further noted that Petitioner had a lot of stiffness in his sacroiliac join, and hurts when he goes from a sitting to a standing position or if he is supine for a period of time and has to get up. Dr. Newcomer recommended a therapeutic and diagnostic injection into the SI joint. (PX3, at 16)

On October 31, 2012, Petitioner saw Dr. Newcomer for another follow-up. Dr. Newcomer noted that Petitioner's AC joint pain was improving. Petitioner continued to complain of pain over the coccyx as well as the SI joint. Dr. Newcomer noted that Petitioner continued to complain of quite a bit of pain with any forward trunk flexion for any length of time, and pain upon returning to extension directly upon the SI joint. Petitioner indicated that the pain is worst first thing in the morning or after prolonged sitting. Dr. Newcomer observed that more functional quicker movements aggravated Petitioner's SI joint pain in physical therapy. Dr. Newcomer continued to recommend the injections. (PX3, at 17)

On December 7, 2012, Job Bolles, MS-PAC for Dr. Newcomer saw Petitioner in regard to his right lateral elbow pain. Petitioner reported complaints of lateral elbow pain began after beginning work conditioning. Mr. Bolles noted, upon examination, that Petitioner was exquisitely tender over the lateral epicondyle and ECRB tendon, mild pain in the middle finger provocative testing, and reproducible pain with resisted grip and wrist extension. Petitioner was diagnosed with right elbow lateral epicondylitis and a corticosteroid injection into the ECRB tendon was performed. (PX3, at 18)

At that same visit on December 7, 2012, Petitioner was also evaluated on the progress of his SI joint, coccyx pain, and left shoulder issues. Mr. Bolles noted Petitioner had been doing work conditioning with upper and lower extremity strengthening. Petitioner was still dealing with quite a bit of stiffness and soreness in the mornings when he first gets out of bed, mainly in the SI joint area. Petitioner also continued to have some coccyx pain as well. Petitioner's reported that his primary complaint was SI joint when he was active. He reported pain when walking up an incline, moving from sitting to standing, forward flexion, trunk and return to extension, and pain with squatting. It was again recommend that Petitioner receive a SI joint injection for the SI joint pain. Continued work conditioning over the next month was also recommended. (PX3, at 18)

On January 7, 2013, Petitioner returned to Dr. Newcomer over a flare-up with his back. Dr. Newcomer observed that just doing some light shoveling recently caused Petitioner a flare-up in his back that caused sharp, stabbing, mechanical type of back pain that took his breath away. Dr. Newcomer also noted that Petitioner's coccyx was also very painful when sitting and had not improved much at all. With regard to the lateral epicondylitis of the right elbow, which according to Dr. Newcomer occurred as a result of the work conditioning program's repetitive tasks, Petitioner received an injection with 1% 1 cc of Celestone and 3 cc of Lidocaine. Dr. Newcomer then referred Petitioner to a pain specialist, Dr. Carmichael, for an evaluation and injection for Petitioner's mechanical back and coccyx pain. (PX3, at 19)

On January 17, 2013, Petitioner saw Dr. Carmichael at McLean County Orthopedics for his back pain. Petitioner had complaints of pain at the lumbosacral junction and also at the lower tailbone. Dr. Carmichael noted that aggravating factors included prolonged sitting, laying down, standing, and bending. Upon physical examination, Dr. Carmichael diagnosed Petitioner with discogenic pain and a coccyx injury. Dr. Carmichael recommended an intercoccyx injection that day. The doctor also recommended a MRI of the lumbar noting that

Petitioner had undergone about five months of physical therapy and work conditioning but was still not back to work. Dr. Carmichael performed the intercoccyx injection on Petitioner without complication. (PX2, at 80)

At a follow-up on January 24, 2013, with Dr. Carmichael, Petitioner reported that his back was still sore, and that his tailbone pain increased for a couple of days following the injection, but was better at this visit. The MRI results were reviewed and showed shallow right paracentral herniation at L5-S1 and shallow left paracentral herniation at L4-5. Dr. Carmichael recommended right and left transforaminal epidurals. (PX2, at 79)

Petitioner returned to Dr. Carmichael on January 28, 2013. At that time, Dr. Carmichael performed a fluoroscopically guided, contrast controlled left L5 and right S1 transforaminal epidural. (PX2, at 84)

Petitioner followed up with Dr. Newcomer on February 4, 2013. At this time, Dr. Newcomer noted that Petitioner was being seen by a pain specialist for his back, that Petitioner had two bulged disks that had been injected, and that he was to have one addition injection. The doctor noted the injections had not helped much with the pain and that a diskectomy is being considered. With respect to Petitioner's ECRB and tendonitis of the right elbow, Dr. Newcomer noted that Petitioner was feeling much better. Dr. Newcomer recommended a Thera-Band program to work on conditioning. He also noted however, that if Petitioner's symptomatology of lateral epicondylitis returned, then an PRP would be considered. (PX3, at 20)

On February 12, 2013, Petitioner returned to Dr. Carmichael for his continuing back pain. Petitioner reported that he was still having severe back pain and tailbone pain and substantial difficulty sleeping. After an examination and further review of the MRI, Dr. Carmichael recommended a discogram with intradiscal contisone injection at L4-5 and L5-S1 combined with a left L5 transforaminal epidural. Dr. Carmichael noted that if these procedures were not adequate, Petitioner would get a surgical referral. (PX2, at 78)

On February 28, 2013, Petitioner returned to Dr. Newcomer with persistent elbow complaints and flare-ups that began as soon as he started doing exercises with extension. Upon examination, Dr. Newcomer noticed tenderness to palpation in area of complaint, and tenderness with resisting wrist extension and middle finger extension. Given that Petitioner had already been given two Cortisone injections without much benefit, Dr. Newcomer recommended a PRP as an alternative to surgery. (PX3, at 21)

Petitioner returned to Dr. Carmichael on April 18, 2013 with continuing complaints of severe back pain over the sacrum and tailbone. Dr. Carmichael once again recommended a discogram with intradiscal contisone injection at L4-5 and L5-S1 combined with a left L5 transforaminal epidural. (PX2, at 77)

On April 22, 2013, Petitioner underwent a fluoroscopically guided, contrast controlled left L4-5 and L5-S1 discogram with inradiscal cortisone injections and left L5 transforaminal epidural steroid injection and tailbone injection done by Dr. Carmichael. (PX2, at 82)

On May 5, 2013, Petitioner returned to Dr. Newcomer for the PRP procedure. Dr. Newcomer removed twelve cc of blood, spun down and injected the platelet-rich plasma under strict sterile technique into the right lateral epicondylar region of Petitioner's elbow. Petitioner was then instructed to do a follow up where he would receive stretching and icing instructions. (PX3, at 22)

On May 22, 2013, Petitioner was returned to work without any restrictions by Dr. Newcomer. (PX3, at 24) Petitioner then was released by McLean County Orthopedics on May 30, 2013 with no restrictions. (PX2, at 30-32)

At trial, Petitioner testified that he currently experiences pain in his left shoulder when he is working out or if he overdoes things. Specifically, Petitioner testified that the pain limits what he can do physically with his

left shoulder, and that he most recently felt the pain the previous day while performing chest exercises at the gym. Petitioner further testified that he continues to do therapy to strengthen his left shoulder. Petitioner also testified to occasional residual symptoms in his right elbow.

With respect to the coccyx fracture, Petitioner testified that that whole general area feels different than it did prior to the accident. Petitioner testified that he continues to feel pain every day around his tailbone. He testified that he has pain in his tailbone area when he is driving, running, or sitting. Petitioner described the pain as a very dull and aggravating pain. Petitioner continues to perform the suggested therapy for this injury.

Petitioner testified that his back tightens up when running, when he does rows, and when he plays softball. Petitioner testified that he had no such problems before the accident.

What is the Nature and Extent of Petitioner's Injuries?

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

(a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall 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 regards to paragraph (i) of Section 8.1(b) of the Act:

i. In this case, neither party submitted an AMA impairment rating.

With regards to paragraph (ii) of Section 8.1(b) of the Act:

ii. Petitioner continues to be employed in his pre-injury employment as a Correctional Officer with Respondent. The Arbitrator takes judicial notice that this position is a physically demanding position and concludes Petitioner's permanent partial disability ("PPD") will be larger than an individual who performs lighter work.

With regards to paragraph (iii) of Section 8.1(b) of the Act:

iii. Petitioner was only 26 years old at the time of his injuries. The Arbitrator considers Petitioner to be a younger individual and concludes that Petitioner will likely have to live and work for a longer period of time than an older individual with the same injuries.

With regards to paragraph (iv) of Section 8.1(b) of the Act:

iv. At the present time, there is no evidence that Petitioner's future earning capacity has diminished as a result of this injury.

With regards to paragraph (v) of Section 8.1(b) of the Act: 15IWCC0006

v. On July 13, 2012, while undertaking his regular duties Petitioner was involved in an altercation with a 6 foot, 300 pound inmate. The inmate struck him numerous times about the head and upper body. Petitioner sought treatment and diagnosed with 1) left shoulder AC joint sprain and grade 1 separation; 2) left low back pain and spasm; 3) low back SI join strain; and 4) coccyx fracture. Dr. Newcomer, one of his treating physicians believed that there was enough force with the trauma to have thrown his sacroiliac joint out of "whack." During the course of treatment, a CT scan of his coccyx and sacrum showed a healed fracture, but one that had healed in a flexed position. A lumbar MRI performed revealed a shallow right paracentral herniation at L5-S1 and shallow left paracentral herniation at L4-5. Petitioner developed pain over the lateral epicondyle and ECRB tendon during the course of work conditioning. Right elbow lateral epicondylitis was added to his diagnoses. To treat his multiple diagnoses, Petitioner underwent a course of conservative treatment consisting of physical therapy; corticosteroid injection into the ECRB tendon; a SI joint injection for the SI joint pain; an injection with 1% 1 cc of Celestone and 3 cc of Lidocaine; an intercoccyx injection; a fluoroscopically guided, contrast controlled left L5 and right S1 transforaminal epidural; a discogram with intradiscal contisone injection at L4-5 and L5-S1 combined with a left L5 transforaminal epidural; and a PRP procedure. Petitioner was ultimately returned to work without any restrictions. He credibly testified to current complaints regarding his left shoulder, occasional residual symptoms in his right elbow, low back pain and pain every day around his tailbone.

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 applying Section 8.1b of the Act, 820 ILCS 305/8.1b and considering the relevance and weight of all these factors, the Arbitrator finds Petitioner sustained 10% loss of use of the right arm for the right elbow epicondylitis under Section 8(e) of the Act. The Arbitrator further finds that Petitioner is permanently disabled to the extent of 25% (7-1/2% for his fractured coccyx; 7-1/2% for the left shoulder AC joint sprain and grade-1 shoulder separation; and 10% for two herniated disks) under Section 8(d)2 of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Elida Lozano,

Petitioner,

15IWCC0007

vs.

NO: 12 WC 31176

Coolersmart, USA,

Respondent.

DECISION AND OPINION ON REVIEW

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

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

- Petitioner was a 27 year old employee of Respondent, who described her job as a customer service representative. Petitioner resides in East Chicago, Indiana. On the date of accident, Petitioner reported to work under no physical restrictions from any doctor; no restrictions as to walking or standing. Petitioner's job entailed answering incoming customer sales phone calls, making outgoing calls, satisfaction calls, answering e-mails

and doing accounts payable; they would try to collect money on accounts that were past due. Physically, Petitioner stated she would quite often have to go to the file room to pull files to scan whatever was in the file the customer requested, like contracts or outstanding invoices, and then e-mail or fax them to the customer as requested. Petitioner testified that the file room was about 60 feet from her computer station. Petitioner testified that about 60% of her day was spent sitting and standing/walking was probably about 40% of the day. Petitioner stated that other than walking to the file room, she had to walk up and down stairs (about 20 stairs) to the restroom, break room, and the water cooler. Petitioner had to use the stairway 5-6 times per day. It was agreed that Petitioner had an accident working on July 10, 2012. On the date of accident, July 10, 2012, Petitioner testified that she went to the filing room, opened up a file drawer and pulled out the file she needed. Petitioner stated that as she was walking away the hinge broke and the drawer fell onto her left foot. Petitioner testified that the drawer was about three feet wide, metal and completely filled. Petitioner testified that immediately after she had a lot of pain in her left foot. Petitioner did receive medical care that day. Petitioner testified that day she had a conversation with the office manager, JoAnne, and there was the other customer service rep, the dispatcher, and the admin for the pod present for that conversation. Petitioner testified she told JoAnne that the drawer had fallen onto her foot and someone went to get Petitioner ice. Petitioner put the ice on her foot and JoAnne told Petitioner to wait while she contacted human resources. Petitioner was not in front of JoAnne when JoAnne called HR, but JoAnne came back after the phone call and instructed Petitioner to go to Concentra in Willowbrook (as JoAnne had been told by Bill Monroe).

- Petitioner went to Concentra that day and advised them of what occurred. Petitioner stated that Concentra examined Petitioner, elevated and iced her foot, performed x-rays and prescribed crutches and a sit-down job. Petitioner was provided a sit down job by Respondent. Petitioner returned to Concentra two days later and underwent the same treatment. Petitioner stated that she began therapy which she went for 8 times between July 12 and July 26, 2012. The therapy consisted of exercises, electric stimulation, hot/cold packs and ultrasound. Petitioner treated with a Dr. John there. Petitioner returned to Concentra on July 20, 2012 and advised the doctor what she was then noticing. Petitioner was again examined and released to light duty. On July 27, 2012 Petitioner again advised the doctor what she was noticing and the doctor recommended an MRI and referred Petitioner to Dr. Bryniczka, a podiatrist at Concentra's Elk Grove Village location. Petitioner first saw Dr. Bryniczka on August 1, 2012. Dr. Bryniczka also recommended the MRI, of her left foot and ankle, which she underwent that day. Petitioner again met with the doctor on August 9, 2012 and the doctor went over the MRI and recommended surgery. Petitioner saw that doctor two times in August while they were waiting for the surgery to be approved. Dr. Bryniczka subsequently performed the surgery to her left ankle on August 31, 2012, at Alexian Brothers Medical Center. Petitioner had follow up appointments with the doctor September 8 and 29, 2012. Petitioner started missing work on August 31, 2012. Petitioner continued with doctor follow ups in October 2012 and he started therapy at Concentra. On November 10, 2012

the doctor examined Petitioner, advised her to continue therapy and released her to return to work at reduced hours and reduced physical activity. Petitioner was provided with modified work by Respondent from November 19, 2012 through January 5, 2013. Petitioner continued to see the doctor and with therapy during that time period. She was again examined on December 29, 2012 and the doctor took another x-ray of her left ankle. Petitioner had been using an air walker following the surgery, after the cast. The cast had been removed after about 4 weeks and then she used the air walker/moon boot. Dr. Bryniczka again examined Petitioner on January 14, 2013 and continued the therapy which at that time was being conducted at Concentra in Hammond, Indiana. She saw the doctor again on January 15, 2013 who did not then recommend further treatment pending the examination by Dr. Kelikian January 28, 2013.

- Petitioner saw Dr. Kelikian for an examination at Respondent's request on January 28, 2013. Petitioner returned to Dr. Bryniczka on February 6, 2013 and he recommended further therapy which was not authorized pending the §12 examination (independent medical evaluation [IME]) report. Following Dr. Kelikian's exam, the doctor recommended Petitioner have an ultrasound examination which was performed on April 8, 2013 at Northwestern. Dr. Kelikian went over those results that day and prescribed physical therapy and Voltaren gel. At that time, Dr. Kelikian became Petitioner's treating doctor. On April 24, 2013, Dr. Kelikian examined Petitioner and advised her to start therapy. Petitioner went to ATI three times in April and five times in May 2013. Dr. Kelikian ordered a functional capacity evaluation (FCE) on May 20, 2013 which was done May 30, 2013 at ATI. Dr. Kelikian released Petitioner to return to work on July 8, 2013 after his examination. Petitioner has not seen the doctor since that date and the doctor imposed restrictions of a sedentary job only.

- Petitioner's workers' compensation benefits were terminated on July 4, 2013. Petitioner kept a record of her mileage for the various doctor visits. Petitioner agreed she had first seen Dr. Bryniczka at the Concentra facility in Elk Grove Village and he had directed Petitioner to Dr. John at the Concentra location in Willowbrook. Petitioner believed she had been seeing Dr. Bryniczka at the Concentra locations about once per week and he gave her follow up appointments at whatever office he was at on his rotating Saturday schedule. Petitioner testified those Concentra locations were located in Wheaton, Niles, South Elgin, Streamwood, Aurora, and in DeKalb (she did not go to that location). Petitioner testified that she drove from her home in East Chicago, Indiana to those various locations and she had kept a running tally on her computer regarding her mileage to those medical appointments for every trip. She kept track via the odometer reading on her car and she had taken the quickest and most efficient routes there.

- Petitioner testified currently she has pain in her left foot. She noted she also now has pain in her right foot and it is difficult for her to go up and down stairs at home; she finds herself falling down stairs quite often. Petitioner stated that she cannot bear any weight on her left foot so she overcompensates with her right foot. Petitioner testified she walks

with a slight limp, not too bad, but she does not walk completely straight and normal now. Petitioner testified that she can stand for a couple of minutes before she starts to notice pain in her left foot. Petitioner did recall the therapist at ATI asking her to stand in place during the FCE; however, she stated that she stood bearing most of her weight then on her right foot. While she was convalescing from surgery, Petitioner testified that she did go for bicycle rides, probably in May or June at the suggestion of her therapist. Petitioner stated that she rode about 6 miles. Petitioner had been given a home exercise program. Petitioner stated that the therapists had also suggested that she walk and she tried to walk as much as she could and as far as she felt she could walk. Per the therapy records, Petitioner walked 2.5 miles one weekend; however, Petitioner stated that was split up over the two days. Petitioner testified with that she had noticed she had a lot more pain in her left foot and after that she tried not to do that.

- Petitioner viewed PX 5 and indicated it was the printout of her mileage entries. Petitioner testified that the information was true and accurate to the best of her knowledge. Petitioner testified that prior to July 10, 2012 she had injured her back in 2004 when she had been rear-ended in a car accident; she did not have surgery as a result of that accident, but she had been diagnosed from that with herniated discs in her back at L3, L4, L5. Petitioner had that back condition when she started working for Respondent in February 2011 but she had been able to perform her work duties. Petitioner testified that prior to this accident she had no conditions regarding either foot, and Petitioner had no restrictions involving her ability to stand or walk. Previously Petitioner never had experienced any accidents involving her left foot/ankle.

- Petitioner did have her Bachelor's degree from Purdue University and prior to this accident she had applied to graduate school. Petitioner testified that since this accident she had started graduate school at Indiana University Northwest working on her Masters degree in Education. Petitioner is considered part-time (8 credit hours) as she is going to school at just under full-time (9 hours is considered as full-time). While attending school Petitioner testified in regard to her left foot/ankle that it is hard to stand, like when she is called to the board to do practice problems, she cannot stand still; she is constantly moving her feet because they hurt, so she just keeps switching back and forth; like she is standing on a hot stove. Petitioner hopes to teach Math some day so that does involve using the blackboard. Petitioner testified that since her benefits had been stopped she has looked for work. Petitioner stated she had only applied to 4-5 places for customer service jobs and was unable to find anything to get any offers.

- On cross examination, Petitioner testified she had physical therapy in Hammond, Indiana about 9 miles from her house. She was directed by Concentra to go there; there are places closer to her home. Petitioner agreed there are podiatrists in her area. Petitioner drove to the hearing. She had no problems driving; she had no restrictions on driving. As to the therapist noting she had ridden a bike and walked 2.5 miles, Petitioner stated that she did inform the therapist that she was in pain. She testified she did not walk as much now,

maybe a mile. She stated she does not actually go out on walks anymore. She had not ridden her bike or done therapy in the past month. Petitioner agreed she had been released by Dr. Kelikian's note of June 14, 2013, consistent with the FCE. She did not receive a copy of that note. After Petitioner was told she could return to light or sedentary duty, she did not return to work at Respondent as she was aware that Respondent had eliminated those jobs. Petitioner was not doing her regular job when she returned to work in January and was receiving temporary partial disability (TPD).

- When Petitioner testified she was injured she had gone to retrieve a folder with 1-20 papers in it. Her intent was to pull the file and return to her desk. Normally she would go and scan, copy or e-mail what was needed and then return to her desk to make the phone call about it. Petitioner testified that about 25-30% of her normal day had been on the phone, incoming and outgoing calls. Petitioner testified the rest of the time was spent preparing whatever it was she needed to do for either an e-mail or a phone call. Petitioner testified that about 40% of her day was on her feet. She would disagree if someone testified it was far less than that. Petitioner had looked for customer service work 4-5 times. She indicated she could perform those duties if there were not a lot of extra requirements. Petitioner stated that not all customer service jobs are sedentary. Petitioner had filled out an application for Respondent. All of her prior jobs had been in customer service. She stated the dealerships she worked for before were not really light duty; there was a lot of running around. Petitioner goes to school at Indiana University in Gary, Indiana. She walks about 20 feet from the parking lot to the building; she does have a handicapped parking sticker. The podiatrist had given her one and her primary doctor (Dr. Danner) gave her a permanent one. She saw her primary doctor the week before; he does not treat her foot. She had the handicapped placard regarding her back. The FCE noted her inability to lift 2 pounds with her left hand; Petitioner did not injure her left or right hand at Respondent. It noted her complaint of right thigh pain and she did not injure that either at Respondent. Petitioner had complained of low back pain throughout the FCE but she did not injure her back at Respondent. She had complained of neck pain and a stiff neck at the FCE but again she did not injure that at Respondent. Petitioner testified when Dr. Kelikian released her in June or July she did not return to work at her original job at Respondent. Petitioner stated physically she could not do the constant walking back and forth. She stated she would walk back to the file room 4-5 times per day and pull a file to scan or whatever needed each time and walk back to her desk. She did not pull 4-5 files at a time. Petitioner was aware Dr. Kelikian had released her to return to work at Respondent. Petitioner testified she never had a conversation with the doctor regarding the physical requirements of her job. When she first saw him he did ask what she did and she said it was customer service.

- Petitioner testified she sees her primary doctor, Dr. Danner-Roberts in Griffith, Indiana every three months. Her doctor had not imposed any physical restrictions on her due to her back injury and condition; but she agreed her doctor had given her a handicapped parking sticker. The doctor never did give her any physical limitations for the back.

Petitioner is on medication regarding her back condition (Norco, Baclofen, and Ibuprofen as needed). She takes the medications daily. Petitioner viewed PX 1 and identified it as her application for Respondent. Petitioner agreed she is bilingual (Spanish); she can read and write English and Spanish. Petitioner graduated from Purdue University in Hammond (a satellite facility). Her major was Spanish; it was a 4 year program. The degree was actually international studies, in Spanish. The course did not consist of any business classes.

- Going through her employment history, at Suddenlink Communications, Petitioner testified that she was call center technical support primarily, and sales and retention after hours, but that had been just walking customers through technical issues they were having. That was a sit down job at a phone and computer, sitting most of the day. After her release by Kelikian July 13, she first applied for employment in August at NIPSCO, an electric company in Indiana. She made that application online. They were to contact her if she met the criteria but they never called her back. She next applied, in person, with a friend of hers, at Farmers Insurance in Highland, Indiana. Petitioner had spoken to her several times but they were not looking for anyone. Petitioner next applied at Quik Scripts Pharmacy in Lansing; that was from a Facebook posting. Petitioner had spoken to the pharmacist there; he had been her pharmacist personally. She had called him, last back in August. The next she job Petitioner applied for was probably in September; a Craigslist ad; it did not say the company. Petitioner testified that she had submitted her resume to several places on Craigslist in the same fashion. Petitioner does live in Indiana. Petitioner had not contacted the Department of Rehabilitation Services in Indiana; she did not even know what that was. Petitioner had not contacted any former employers to try to get hired. Petitioner had applied for unemployment compensation. Petitioner agreed that she had to do a job search for that, and that she had filled out paperwork associated with her job search. Petitioner stated that she did have copies of that search; she believed 2-3 per week.

- Petitioner testified that she lives about 9 miles from the Purdue campus and she had not been back there since July 2013. Petitioner stated that she had not contacted Purdue's employment programs. She currently is going to a satellite campus of Indiana University; she had not gone through their employment offices. Petitioner began at that campus in August 2013; 3 days per week. Petitioner agreed that no doctor told her to change professions. Petitioner recalled testifying that on the date of the accident she talked to JoAnne Rosinski, the office manager; a dispatcher and another customer service rep were present. Petitioner testified that JoAnne is still working there; Petitioner had been back there a couple months prior. Petitioner believed the dispatcher was Donna Wisinski and the rep was Karen Tate. When she goes to school she does park in a handicapped space and walks to the door, about 20 feet. Her class is on the 4th floor and she uses the elevator and the room is right there. Petitioner agreed the distance she goes to the classroom is about the same as in the office getting a file. Her other class is in the next building. There is a gap between her classes so she goes home then returns; she does travel a similar

distance. Petitioner agreed she is taking no prescription medications regarding her foot injury. Petitioner agreed the boots she was wearing for hearing had a 1-1/4inch heel. Petitioner agreed the last doctor she saw regarding her foot was Dr. Kelikian in July 2013 and she had no scheduled appointments to return.

- On redirect examination, Petitioner testified that she had learned of Respondent through Craigslist as noted in RX 1. Petitioner testified that at no time did Respondent or their carrier offer to provide her with vocational assistance or help her find work. Petitioner agreed the distance to her classroom is about the same as walking to the file room to get a file. She walks to the class room once a day. Prior to this accident, Petitioner never had a prior workers' compensation (WC) claim.

- Petitioner testified that JoAnne took her to Concentra right after the accident and Dr. John had referred her to Dr. Bryniczka at that Concentra location in Elk Grove Village. Petitioner testified that between July 10th and July 27th 2012, no one from Travelers or Respondent explained to her that she had a right to choose her own doctor; Petitioner testified she was just trying to go along with the program. Petitioner first saw Dr. Bryniczka on August 1, 2012 and the doctor performed the surgery on her left foot on August 31, 2012. Petitioner did not dispute that her WC's claim was filed September 10, 2012. Petitioner had not consulted an attorney prior to that surgery.

- On re-cross examination Petitioner testified, in regard to riding a bike 2.5 miles, that she had not done that since as she is in pain in her left foot and her back. Petitioner lost her job on February 7, 2013. Petitioner testified that Respondent hire a temp, Maureen, to assist customer service in pulling files and scanning documents; essentially as a runner. Petitioner testified Maureen was let go at the end of 2012. Petitioner had worked several months in 2012. Petitioner testified for the 5-6 weeks she worked in 2013 she was in customer service but her office was then downstairs; she did not have to go upstairs, the upstairs people would bring the files down to Petitioner.

- Petitioner indicated (regarding Respondent's questions of getting multiple files at once) that she did not wait to get 4-5 files. She stated that may have been more efficient, but many times the customers were waiting so she would do that first so they did not wait as long and also so she would not forget what she was doing. She indicated that was not a specific instruction from JoAnne. Petitioner did not have conversations regarding files stacking up and JoAnne did not say anything about that. From July 10, 2012, Petitioner testified she had no other accidents of any kind regarding any part of her body. Petitioner agreed she is currently in graduate school; that was planned prior to this accident. She did have to submit letters of recommendation to the school (one from a Purdue adviser, one from a professor, and one from Bill Monroe, HR at Respondent). At school Petitioner can schedule her classes in the evenings or on Saturdays if necessary. Petitioner stated that she returned to school in August 2013 which was not her original plan. Petitioner stated that she originally planned to return to school in August 2012 and to continue working at

Respondent at the same time. As to her job application at Respondent, she noted that she left Suddenlink Communications as she had relocated. Petitioner noted that she had been laid off from Napleton River Oaks Chrysler Dodge. Petitioner had also worked at St. Joseph's Carmelite Home for Girls as a front desk receptionist before she moved to Texas. Petitioner also had worked for an auto group in Indiana prior to that and had been laid off from them also.

- On re-cross examination, Petitioner agreed there were 2 positions of customer service reps at Respondent's Illinois location. No one else had the position besides Karen Tate and Petitioner. Petitioner testified that those positions had been transferred to Delaware.

- Petitioner, testified again, on direct examination, on January 9, 2014. Petitioner stated that she had no further medical treatment since her last testimony on November 19, 2013. Petitioner had previously noted what she noticed as a result of this accident and nothing had changed since her prior testimony. No one had contacted Petitioner as to any vocational rehabilitation since that hearing. Petitioner had looked for work since the prior hearing; about 15 places for jobs like administration, secretarial, and clerical. She had searched via Craigslist and indeed.com. She had no interviews from her search and had not been offered any work. Petitioner does have health insurance.

- On cross examination, Petitioner testified that she did not bring a list of her job search efforts.

- Respondent's witness testified regarding Petitioner's job duties.

The Commission finds, regarding the issues of temporary total disability (TTD), and vocational rehabilitation, that the Arbitrator noted the functional capacity evaluation (FCE) restrictions related to her low back and right leg pain and stiff neck and neck pain and also restrictions related to upper extremity weakness as not being causally related to this left foot/ankle injury. The Commission notes that Petitioner testified of being unable to return to her former job relative to her foot injury and requested maintenance and vocational rehabilitation. But for Respondent having transferred those jobs to Delaware, Petitioner would apparently be working at Respondent per Respondent's witness, Ms. Wisinski. The Commission finds that Petitioner's job was really considered essentially light/sedentary work. Petitioner is a college graduate and is working towards obtaining further advanced degree. Petitioner testified of doing a limited job search but provided no log of her search. Respondent's, Ms. Wisinski's, testimony rebutted Petitioner's testimony of the amount of walking and standing Petitioner performed in her job and Petitioner testified of prior jobs that were even more sedentary. There is no indication of an unstable job market for Petitioner given her experience, age, and current pursuit of an advanced degree. There is no evidence Petitioner could not perform even her former duties within the valid FCE findings and release by Dr. Kelikian. Much of Petitioner's difficulties seem to arise from her unrelated back and other conditions. Also there is no indication or evidence that Petitioner could not be earning the same wage. Petitioner certainly appears as trainable and she is, in fact,

pursuing that training on her own for an advanced degree to possibly teach. The evidence indicates Petitioner is in school pursuing her advanced degree and she performed a very limited job search and does not appear, under the circumstances, to really want to find a job while in school. The Commission notes that Petitioner's testimony was rebutted by Respondent's witness as to the amount of time walking/standing required in Petitioner's former job with Respondent. Petitioner is 27 years old with a college degree and is currently working to obtain her Masters degree in hopes of teaching. Respondent's witness testimony is consistent with Dr. Kelikian's release indicating Petitioner's job was below the findings of the FCE and she was, therefore, capable of returning to that employment as to her foot condition (the back condition was MVA related). The evidence and testimony finds support that Petitioner was entitled to the TTD as awarded but Petitioner failed to meet the burden of proving entitlement to further TTD/maintenance benefits beyond Dr. Kelikian finding Petitioner at maximum medical improvement (MMI) in July 2012. Further, the same evidence noted finds Petitioner failed to meet the burden of proving entitlement to any vocational rehabilitation as she failed to prove the required elements, again as noted in the Arbitrator's decision and above. The Commission finds the decision of the Arbitrator as not contrary to the weight of the evidence, and herein, affirms and adopts the Arbitrator's finding as to total temporary disability/maintenance, and further affirms and adopts the Arbitrator's finding as to denial of vocational rehabilitation benefits. The TPD, due was not in dispute and it is noted to have been paid for the 6-6/7 weeks.

The Commission finds, regarding the issue of mileage, evidence and testimony that Petitioner followed through with the 'company doctors' at Concentra whether she was advised she had a choice of doctors or not. The Concentra doctors referred Petitioner to various facilities in the Chicago suburbs and Dr. Kelikian (IME then treater) in Chicago (Petitioner's only real choice as treater). The therapy at Concentra's Indiana location was the closest (about 9 miles) to Petitioner's home. The Commission notes Petitioner's travel for her classes to be in the same proximity to her home as for the therapy. The Commission finds that that other than the initial evaluation with Dr. Kelikian, no mileage expense should be awarded for those visits as she opted to treat there as her choice. Further, although Petitioner had been referred for therapy via Concentra, to the therapy in Indiana (9 miles from her home), those travel expenses should not be awarded as clearly those cannot be considered too far or out of the way, to warrant those to be awarded regardless of how Petitioner got there. The Commission finds the decision of the Arbitrator as not totally contrary to the weight of the evidence, and herein, modifies the mileage award denying the mileage for Petitioner's Dr. Kelikian visits (other than the initial evaluation visit), and denying mileage for the therapy visits within close proximity to her home. Therefore, the mileage for the 34 visits for therapy and the 'treatment' visits with Dr. Kelikian are denied to reduce the mileage travel award to $2,121.35.

The Commission notes that Respondent presented questions under §19(e), filed November 5, 2014, which submission is addressed under separate Order.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $366.16 per week for a period of 32-3/7 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 $2,121.35 for medical mileage expenses under §8(a) of the Act.

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

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

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury. (Respondent has paid $22,874.20 in temporary total disability benefits)

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $2,300.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JAN 9 - 2015
o-11/13/14
DLG/jsf
45

David L. Gore

Stephen Mathis

Mario Basurto

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

LOZANO, ELIDA
Employee/Petitioner

Case# **12WC031176**

15IWCC0007

COOLERSMART USA
Employer/Respondent

On 4/3/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.06% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1836 RAYMOND M SIMARD PC
221 N LASALLE ST
SUITE 1410
CHICAGO, IL 60601

0532 HOLECEK & ASSOCIATES
LAWRENCE SZYMANSKI
161 N CLARK ST SUITE 800
CHICAGO, IL 60601

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

- ☐ 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)

15IWCC0007

ELIDA LOZANO,
Employee/Petitioner

v.

COOLERSMART, USA,
Employer/Respondent

Case # **12** WC **031176**

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 19, 2013 and January 9, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **07/10/2012**, 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* partially causally related to the accident.

In the year preceding the injury, Petitioner earned $**11,534.10**; the average weekly wage was $**549.24**.

On the date of accident, Petitioner was **27** years of age, ***single*** with **1** dependent children.

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

Respondent shall be given a credit of $**11,874.20** for TTD, $**1,578.39** for TPD, $**0** for maintenance, and $**4,036.42** for other benefits, for a total credit of $**17,489.01**.

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

ORDER

Respondent shall pay Petitioner TTD benefits of $366.16 per week for 32 3/7 weeks, commencing August 31, 2012 through November 18, 2012 and from February 8, 2013 through July 4, 2013, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner TPD benefits of $230.18 per week for 6 6/7 weeks, commencing November 19, 2012 through January 5, 2013, as provided in Section 8(a) of the Act.

The Petitioner's Petition for Vocational Rehabilitation and Maintenance is hereby denied. These benefits are not awarded.

Petitioner's Petition for Mileage and Travel Expenses for attending treatment and therapy appointments is awarded in the amount of $ 2,461.01.

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

03-26-14
Date

APR 3 - 2014

ICArbDec19(b)

STATEMENT OF FACTS

On July 10, 2012, the Petitioner worked as a customer service representative for Respondent in Burr Ridge, Illinois. The job consisted of taking incoming calls from customers for scheduling service calls and visits, and it also included an element of collections on past invoices.

The portion that consisted of collections would require the Petitioner to pull invoices from a vault room. This would require walking from 40-60 feet in a round trip to go to the vault room, pull the invoice (a manila folder with 1 or 2 pieces of paper in it), possibly scanning a portion of the file at a photocopy machine and returning to her desk to discuss the invoice with the customer.

The Petitioner testified that she was on her feet walking to pull invoices at least 3 ½ hours per day.

Prior to July 10, 2012, the Petitioner had no physical restrictions imposed upon her and she had never previously injured her left foot. However, she had 3 herniated discs in her back from a vehicular accident and was receiving active medical treatment with her primary care physician. This included medications and regular visits. She testified that the primary care physician never administered treatment for her left foot. At the time of the Petitioner's testimony she was given a handicap parking permit for her vehicle. This was related, again, to her back condition and not to her left foot condition.

On July 10, 2012, while pulling an invoice, the drawer from the cabinet fell upon her left foot striking it on the dorsum aspect. She felt immediate pain and contacted her supervisor.

At her supervisor's direction, she went to Concentra (Pet. Ex. #1) in Willowbrook and began receiving physical therapy and treatment there. She had ongoing pain and problems with the foot and she was subsequently referred to a podiatrist in Elk Grove Village, again near the employer's location, who was identified as Dr. Adam Bryniczaka. (Pet. Ex. #2)

The Petitioner continued to work until she was authorized off from work for surgery on August 31, 2012. She underwent arthroscopic surgery for an anterior talofibular ligament rupture. (Pet. Ex. #2) She was followed postoperatively by Dr. Bryniczaka but had continued complaints of pain involving the left foot.

She was released to modified duty with limited hours beginning November 19, 2012 through January 5, 2013. Respondent voluntarily paid the wage differential as stipulated to by the parties. On January 6, 2013, she returned to regular duty but had continued complaints of left foot pain and problems.

An Independent Medical Evaluation was set with Dr. Armen Kelikian (Resp. Ex. #2) and he conducted an evaluation on January 28, 2013. (at 6) Dr. Kelikian was concerned that there might be a tendon lesion and therefore recommended an ultrasound test to confirm or deny that possible diagnosis. (at 10-11) The ultrasound was eventually performed and showed "a little

tendinosis [inflammation]" (at 12) with no evidence of a tendon tear. Dr. Kelikian assumed treatment and ordered therapy and a Functional Capacity Evaluation. (at 13)
The Functional Capacity Evaluation (Pet. Ex. #4) indicated functional capabilities of the "light physical demand level" with significant lifting restrictions. The examination was performed on May 30, 2013 and noted that she could walk 3-4 hours a day for occasional short distances. She could stand 1-2 hours in 20 minute duration. She could sit for 8 hours. The examination also indicated significant lifting restrictions, significant lower back pain, right leg discomfort, a stiff neck and, of course, left ankle pain.

The physical therapy notes from ATI show that on April 29, 2013, she was riding her bike 6-7 miles and walking 2 ½ miles over the weekend. She subsequently testified that she no longer walks or rides her bike.

On May 20, 2013, following the Functional Capacity Evaluation, Dr. Kelikian felt that the Petitioner was at maximum medical improvement. (at 15-16) Dr. Kelikian indicated that the Petitioner was a customer service representative in the sedentary to light-duty capacity. Since the Functional Capacity Evaluation released her to a light physical demand job which is above sedentary he felt that she was capable of returning to work with those restrictions.

Dr. Kelikian testified that the inability to lift due to pain because of her low back condition is not related to this incident involving her left ankle. (at 18) Her low back pain is not causally connected to this accident involving the left foot. (at 19) Dr. Kelikian felt that the right leg pain was not causally connected to this accident as well. (at 20) Ultimately, Dr. Kelilkian felt that the 2 lb. lifting restriction and other lifting limitations were not causally connected to the ankle injury stating that "It wouldn't have anything to do with it." (at 20-21)

As of June 17, 2013, Dr. Kelikian felt that the Petitioner was at MMI and no additional treatment was warranted (at 22). Dr. Kelikian felt she could return to her former gainful employment as a customer service representative. (at 23)

Following Dr. Kelikian's final report, TTD benefits were terminated after July 4, 2013.

Ms. Donna Wisinski testified on behalf of the Respondent. She is the dispatch manager and was the immediate supervisor of the Petitioner. As dispatch manager her first function was to get the morning shift ready with necessary product out of the warehouse. This would take her from 7:00 a.m. to approximately 8:30 a.m. She would then return to her desk just a few feet away from the Petitioner's work station. She described the work station for the Petitioner as next to the photocopy machine that was used for scanning. If the Petitioner had to pull an invoice, she would have to walk approximately 40 feet round trip to go from her desk, to the vault to pull the invoice, and return to the photocopy machine or desk. She testified that there were 2 customer service representatives taking calls all day long. They did do about 6 collections each per day. She stated that, at most, an individual would take 4 minutes to walk from her desk to secure an invoice and return. The work shift for the Petitioner was 8:00 a.m. to 5:00 p.m.

The 2 customer service representative positions were analyzed and subsequently moved to Delaware at the company's headquarters. Customer service representative positions are no longer available in Burr Ridge, Illinois. In order to properly evaluate the transfer of these jobs, calls were analyzed and call volume interpreted. Each customer service representative fielded

55-65 calls per day. If both customer service representatives were busy the calls would fall to Ms. Wisinski as their backup. She rarely received any calls. She testified that the Petitioner was sitting at her desk most of the day. Representatives would occasionally get up to stretch or to pull an invoice, but those invoices were pulled only 5-6 times per day. At 4 minutes per invoice, this would take, at most, under a 1/2 hour of walking per day. Ms. Wisinski indicated that she would not be doing her job as a supervisor if she allowed a customer service representative to be away from the phones for 3 1/2 hours per day. She stated that the job duties of a customer service representative were within the physical restrictions imposed by the Functional Capacity Evaluation.

The unrebutted testimony is that it takes 4 minutes to pull an invoice and the Petitioner stated that she would only pull 1 invoice at a time. She insisted that she was on her feet for at least 3 1/2 hours per day pulling these invoices. If that were true, she would be pulling at least 52 invoices per day to call on collections. (3.5 hours = 210 minutes; 4 minutes per invoice = 52.5 invoices per day) Only 5 or 6 collections were called per day per representative.

The Petitioner testified in rebuttal that Ms. Wisinski was never at her desk suggesting that she was in the warehouse. Ms. Wisinski testified that the warehouse was not air-conditioned or heated and that after 8:30 a.m. all of the drivers were out and supplied. She would have no need to be in a cold warehouse and it was simply not the case that she was not at her desk.

The Petitioner testified that she has a college degree and that she is bilingual in English and Spanish. Her primary language is English. The job paid her approximately $13.75 per hour.

The Petitioner testified that she has been unable to find gainful employment since being released to return to work pursuant to the Functional Capacity Evaluation. She asserted that she could not return to her former gainful employment because of the significant restrictions imposed by that Functional Capacity Evaluation.

The Petitioner testified under cross-examination that she applied for 5 jobs between the termination of TTD benefits on July 4, 2013 and the time of her initial testimony on November 19, 2013. Two of those jobs were with friends. She has not had any job offers. She had also testified that she is attending a Master's Program at Purdue University; NW Indiana campus. She hopes to be a math teacher. She is collecting unemployment compensation while going to school full-time. Additional cross-examination elicited the fact that she has to apply to 2 jobs per week pursuant to the Unemployment Compensation requirements. She could not identify a specific employer that she had applied to by name.

When the Petitioner testified on January 9, 2014, she stated that she is still looking for work pursuant to the requirements of the Unemployment Compensation. Again, she could not identify a single employer that she has applied to for employment. She did not produce a list of contacts.

In Support of the Arbitrator's Decision relating to (F), causal connection, the Arbitrator makes the following findings:

The Functional Capacity Evaluation defined various restrictions related to low back pain, right leg pain and a stiff neck. The restrictions also related to significant weakness in both upper extremities.

Dr. Kelikian testified that the restrictions imposed for lifting are related to low back pain, right leg pain, neck stiffness and upper extremity weakness and were not causally connected to this occurrence. There is no medical opinion offering a causally connection opinion to this accident.

The Arbitrator finds that the restrictions imposed on the Functional Capacity Evaluation relating to lifting, pushing, and pulling are not causally connected to the accident in question here. Generally speaking, the physical restrictions of light physical demand level are applicable because of a walking restriction of 3-4 hours and standing restriction of 1-2 hours.

The Arbitrator finds that the Petitioner sustained a left ankle injury only with rupture of a ligament and surgical repair.

In Support of the Arbitrator's Decision relating to (L and O), maintenance and vocational rehabilitation, the Arbitrator makes the following findings:

The Petitioner testified that she cannot return to her usual and customary line of employment because of the physical restrictions imposed by this foot injury. She has requested a vocational assessment pursuant to the Rules. She demands the payment of maintenance.

The Rules Governing Practice before the Illinois Workers' Compensation Act places the burden upon the Respondent to provide a vocational assessment and rehabilitation under certain circumstances. :

> "The employer... shall prepare a written assessment...and if appropriate, rehabilitation required to return the injury worker to employment when it can be reasonably determined that the injury worker, as a result of the injury, will be unable to resume the regular duties in which he was engaged at the time of injury..." [50 Illinois Administrative Code Section 7110.10(a) as amended.]

In *National Tea Company vs. Industrial Commission (1983) 97Ill.2d 424,* our Supreme Court delineated factors appropriate for vocational rehabilitation. Among these multiple factors, and certainly implicit within all of them, is the motivation of the injured worker to find gainful employment. The burden is on the Petitioner to establish that she is motivated to find work and that a vocational rehabilitation plan is necessary to find that employment. Additionally, our Rules have imposed a duty upon an employer even before a Petitioner establishes an inability to return to work due to physical restrictions. That duty is triggered when the restrictions prevent her from returning to her usual and customary line of employment.

The Petitioner is a college graduate, 27 year old female who had worked in customer service in a light-duty/sedentary position. She asserts that she could not perform the physical requirements of the job because she is limited to walking 3-4 hours per day and standing 1 hour per day. Her testimony was directly impeached by the supervisor who described the job as sedentary with sitting at a desk and answering phones all day long. This is consistent with the treating physician, Dr. Kelikian, who released the Petitioner back to this position well aware of both the physical restrictions imposed and the job duties.

The Petitioner has failed to establish that there is no reasonably stable labor markets within her physical restrictions, related to this claim. She could identify only 5 potential employers where she provided applications for employment and 2 of them were friends. This is over the course of 6 months. She continues to collect Unemployment Compensation and attends a graduate program to become a school teacher.

In addition, the first requirement under *National Tea* is that there be a reduction in earning power. The Petitioner earns approximately $13.75, is bilingual, college educated and accepted in a Master's Program at a Big 10 School. She has presented no evidence whatsoever that she has a reduction in earning capacity as a result of this injury and the restrictions imposed.

The second requirement for vocational rehabilitation is the loss of job security. Clearly, this job was eliminated and moved to Delaware and the Petitioner lost that security when this business decision was made. Her injury has nothing to do with this loss of job security.

The third and critical requirement is the likelihood that she could obtain employment using vocational rehabilitation. The Petitioner has demonstrated an unsatisfactory job search. She has shown no motivation to find gainful employment and, instead, is collecting unemployment compensation and going for a Master's program. Although commendable that she wishes to pursue further education, there was no expert opinion provided suggesting that a graduate school program is part of a vocational rehabilitation plan. The Petitioner has demonstrated no need for vocational rehabilitation that it will help her find gainful employment.

The fourth requirement is where vocational rehabilitation has been provided but unsuccessfully; that is not relevant here.

The fifth element is whether the Petitioner is "trainable" due to age, education, skills and training, for finding new employment. She has been released back to her former position of a customer service representative. Although her particular job has been eliminated the Petitioner has provided no evidence that there is suddenly a reduction in customer service representatives in the greater metropolitan area that would necessitate retraining. Further, her skills include the fact that she is a college graduate and bilingual. No evidence was presented by the Petitioner that she requires retraining to secure a job in the area of $13.75 per hour. She is 27 years of age with an impressive education. She has been accepted in a graduate program.

The sixth element considered by *National Tea* is whether she can find employment without further training and education. The Petitioner's background answers this itself. Petitioner has not gone to her alma mater to seek help in finding employment opportunities; she is bilingual and has a college degree. She is accepted in a Master's program; she earned just $13.75 per hour. She testified to no limitations that would prevent her from finding gainful employment in the light or sedentary areas in the metropolitan Chicago land area. She is clearly employable. She provided no evidence that she requires vocational rehabilitation or training to find gainful employment.

The final factor under *National Tea* is the cost and benefits derived from such a program. This Petitioner appears to be unmotivated to find gainful employment at this time as it would certainly interfere with her Master's program education. The cost would be exorbitant in view of the fact

that she is seeking alternative employment as a primary school educator. Transient employment to bridge her until she gets her degree is not Respondent's duty under the law.

The Petitioner has the burden to prove the necessity of such a program. She has failed to meet that burden.

First, the treating physician release the Petitioner to return to her former gainful employment. Second, although she testified that she cannot perform the requirements of that job because she is on her feet 3 1/2 hours a day, that testimony is simply not credible in light of the significant contradictions and evidence provided by Respondent. Further, the job duties of a customer service representative are classified as light duty to sedentary and the Petitioner is released to light duty to sedentary as a result of the Functional Capacity Evaluation.

The Petitioner has failed to establish her burden that she is entitled to maintenance or a vocational assessment or rehabilitation program. As a result, these benefits are not awarded.

In Support of the Arbitrator's Decision relating to (O), mileage, the Arbitrator makes the following findings:

The Petitioner submitted mileage expenses (Pet. Ex. #4) for visits to physical therapy, doctor visits, surgery visits, etc. She asserts that she is entitled to reimbursement for mileage because the employer initially referred her for medical care to Concentra.

The Petitioner testified that she was sent to Concentra for initial medical care following the injury. She continued to treat with Concentra thereafter. Concentra then referred the Petitioner to a podiatrist. She continued to treat with that podiatrist and ultimately had surgery. She went to Dr. Kelikian under a Section 12 examination and the Section 12 travel voucher was paid. However, Dr. Kelikian then assumed medical treatment and she seeks reimbursement for those expenses as well.

Generally, the Illinois Workers' Compensation Act does not require an employer to pay for a Petitioner's travel expenses for ongoing medical care. An exception was defined under *General Tire & Rubber Company vs. Industrial Commission (1991) (221Ill.App.3d 641).* There the Court held that travel expenses for treatment was necessary and should be awarded because the medical providers were so far geographically removed from the Petitioner's home and those providers were the closest reasonable providers for the services sought. The Appellate Court held that the Petitioner established that it was reasonably necessary to travel outside the Mt. Vernon area for medical treatment because that treating physician had been the Petitioner's treating physician for over 7 years. This doctor was most familiar with the Petitioner's condition and it was reasonable for the Petitioner to continue to seek treatment from that treating physician.

Here the Petitioner sought initial medical treatment from Concentra, a medical provider that the Petitioner was directed to by the employer. Concentra then referred the Petitioner to Dr. Bryniczka, who treated the Petitioner at his convenience in Aurora, South Elgin, Elk Grove Village and Wheaton. This was still within the employer's chain of referrals and as a result, is not her choice of physician.

Petitioner kept a detailed log of her mileage and tolls. Using the 55 cents per mile allowed by the IRS, she claims $ 2,461.01 in mileage and toll expenses, which the Arbitrator awards.

STATE OF ILLINOIS) BEFORE THE ILLINOIS WORKERS' COMPENSATION
) SS COMMISSION
COUNTY OF COOK)

Elida Lozano,

Petitioner,

vs. NO. 12 WC 31176

Coolersmart, Inc,

Respondent.

ORDER

This matter came before the Commission on Respondent's §19(e) motion of submitted questions regarding the Review. The Commission having jurisdiction over the persons and subject matter and after being advised in the premise finds:

- This matter was timely and properly filed before the Commission for an accident date of July 10, 2012.
- The matter was heard by Arbitrator Carlson under §19(b) of the Act with the decision being filed April 3, 2014. Thereafter, both parties filed their Petitions for Review.
- Respondent filed this §19(e) motion November 5, 2013 and the matter heard by Commission November 13, 2014, with the oral arguments on Review. Thereafter, the Commission took the matter under advisement.

The Commission notes that §19(e) of the Act states, in part, that:

> In any case the Commission in its decision may find specially upon any question or questions of law or fact which shall be submitted in writing by either party whether ultimate or otherwise; provided that on issues other than nature and extent of the disability, if any, the Commission in its decision shall find specially upon any question or questions of law or fact, whether ultimate or otherwise, which are submitted in writing by either party; provided further that not more than 5 such questions may be submitted by either party. Any party may, within 20 days after receipt of notice of the Commission's decision, or within such further time, not exceeding

> 30 days, as the Commission may grant, file with the Commission either an agreed statement of the facts appearing upon the hearing, or, if such party shall so elect, a correct transcript of evidence of the additional proceedings presented before the Commission, in which report the party may embody a correct statement of such other proceedings in the case as such party may desire to have reviewed, such statement of facts or transcript of evidence to be authenticated by the signature of the parties or their attorneys, and in the event that they do not agree, then the authentication of such transcript of evidence shall be by the signature of any member of the Commission.

The Commission finds that while Respondent's questions submitted are numbered as one through five, the questions clearly are set out as compound questions such that Respondent presents more than five questions to be addressed by the Commission, and as such, that clearly would be found to be beyond the number of questions allowed under the Act. The Commission therefore denies and dismisses Respondent's §19(e) questions as submitted. Regardless, the Commission notes that the Arbitrator's decision addressed the issue, and the Commission's Decision on Review affirmed and adopted that decision, albeit with some modification, regarding the mileage awarded.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Respondent's Motion under §19(e) is hereby denied and dismissed.

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: JAN 9 - 2015

David L. Gore

Stephen Mathis

Mario Basurto

DLG/jsf
11/13/14
045

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

NICOLE ANDERSON,

Petitioner,

15IWCC0008

vs.

NO: 12 WC 24825

HEARTLAND AUTOMOTIVE SERVICES,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical expenses, prospective medical care and temporary total disability, and being advised of the facts and law, reverses the Decision of the Arbitrator as stated below.

Findings of fact and conclusions of law

The Commission finds:

1. Petitioner was a Lower Bay Technician for Respondent. His duties required him to work in a lower bay area under vehicles to perform repairs.

2. On June 3, 2012 Petitioner testified that he was underneath vehicle taking a skid plate down in order to undo a drain plug when he felt discomfort in his neck. He testified that his head was titled to the side and he was pulling on an oil filter at the time. He stated that he had originally felt this discomfort a day or two prior. He informed the Assistant Manager but finished the remaining 6 hours of his shift. Throughout the day the discomfort spread through his chest and both arms, and he began experiencing dizziness. He told the Assistant Manager that he felt like he was having a heart attack. After going home, his condition did not improve, so he drove to the ER at Good Samaritan Hospital.

3. At the hospital an MRI of his neck was recommended. Petitioner testified that he told the doctor that he had been injured at work and that he heard a pop in his neck at the time of accident. However, there was no mention of a work accident in these records. Nor was there a mention of Petitioner hearing a pop in his neck at the time of the alleged accident. Petitioner testified that the ER doctor simply neglected to include these details in his notes.

4. On June 10th a Dr. King took Petitioner off work after he continued complaining of neck discomfort. On July 19, 2012 Petitioner was having numbness in his hands.

5. On August 2, 2012 Petitioner treated with pain specialist Dr. Chami. Dr. Chami noted worsening neck pain after the accident in question, as well as numbness and tingling in his left upper extremity. Steroid injections were recommended. Dr. Chami noted that Petitioner had been off work since June 10th and kept Petitioner off work.

6. A Mr. Richard Borkowski is Respondent's District Manager. He testified that Petitioner never completed an accident report after the alleged accident.

7. An Orthopedic Surgeon by the name of Dr. Robertson testified that he evaluated Petitioner on September 18, 2012 and diagnosed degenerative changes of the cervical spine involving cervical discs and facet joints. He found no neurological changes and opined that degeneration of Petitioner's spine would occur in Petitioner's cervical spine even if he was not holding his neck in a hyper extended position.

8. Additionally, Dr. Robertson testified that Petitioner provided him with a mechanism of injury of hearing a pop while climbing out of the lower bay.

Based on the discrepancy between Petitioner's testimony and contemporaneous medical records, the Commission reverses the Arbitrator's rulings on the issues of accident and causal connection. Although Petitioner testified to completing an accident report after hearing a pop in his neck while his head was titled to the side working underneath a vehicle, medical records are either silent on these issues or indicate something other than the occurrences offered by Petitioner. There is no record of a completed accident report form, the initial ER records do not indicate that Petitioner heard a pop in his neck during a work accident and Petitioner provided a different mechanism of injury to Dr. Robertson than what he testified to at trial.

Accordingly, since Petitioner is unable to sufficiently allege accident and causal connection, the Commission reverses the Arbitrator's ruling and finds that Petitioner failed to prove a work-related accident.

With a finding of no accident and causal connection, the remaining issues of medical expenses, prospective medical care and temporary total disability are also hereby reversed.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner failed to prove he sustained an accident arising out of and in the course of his employment with Respondent on June 3, 2012.

IT IS FURTHER ORDERED BY THE COMMISSION that no medical expenses, prospective medical care or temporary total disability benefits be awarded to Petitioner.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $19,800.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JAN 9 - 2015

O: 11/13/14
DLG/wde
45

Mario Basurto

Stephen Mathis

DISSENT

I respectfully dissent from the majority decision and would affirm the Arbitrator's well reasoned decision in its entirety.

David L. Gore

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

Jill Murphy

Petitioner,

vs. NO. 06WC 50823

Mitsubishi Motors,

Respondent.

15IWCC0009

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, permanent disability, causal connection and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 13, 2014 is hereby affirmed and adopted.

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

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

No bond is required for removal of this cause to the Circuit Court by Respondent.

15IWCC0009

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: JAN 9 - 2015
SJM/sj
o-12/4/2014

Stephen J. Mathis

Mario Basurto

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MURPHY, JILL
Employee/Petitioner

Case# **06WC050823**

06WC050822
09WC050267
11WC012417

MITSUBISHI MOTORS OF NORTH AMERICA
Employer/Respondent

15IWCC0009

On 5/13/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% 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:

0293 KATZ FRIEDMAN EAGLE ET AL
CHRIS MOSE
77 W WASHINGTON ST 20TH FL
CHICAGO, IL 60602

2461 NYHAN BAMBRICK KINZIE & LOWRY PC
ADAM J COX
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602

15IWCC0009

STATE OF ILLINOIS)
)SS.
COUNTY OF McLean)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Case # 06 WC 50823

Consolidated cases: 06 WC 50822, 09 WC 50267, 11 WC 12417

Jill Murphy
Employee/Petitioner

v.

Mitsubishi Motors of North America
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 **Douglas McCarthy**, Arbitrator of the Commission, in the city of **Bloomington**, on **March 25, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **September 15, 2004**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$54,745.60**; the average weekly wage was **$1,052.80**.

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

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

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

Respondent shall be given a credit of **$0.00** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and $0 for other benefits, for a total credit of $0.

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

ORDER

The Arbitrator finds Petitioner did not sustain an accident arising out of and in the course of her employment on September 15, 2004 which was causally related to her alleged injuries.

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.

D. Dan McCarthy
Signature of Arbitrator

April 30, 2014
Date

MAY 13 2014

15IWCC0009

FINDINGS OF FACT

Petitioner works as an Associate for Respondent. She claims an injury to her left hand that occurred on September 15, 2004. (PX 1) On that date, Petitioner reported ongoing problems with the last two digits in her left and right hands, "but Wednesday 9-15 the pinkie on my left hand started feeling like pins and needles and pressure from the knuckle up." (Px1) Petitioner attributed the left little finger complaints to squeezing a rag when she wiped off her fingers. Petitioner is right hand dominant.

Petitioner testified that during 2004 she worked in the sealer department. She alternated between two jobs during that time for a quarter of each workday. The first job was skiving, which she described as using a tool like an eraser to remove excess sealing. The other position required her to apply a sealer. To do this she squeezed a bottle with her right hand and used a rag to wipe with her left.

Petitioner's medical records from Respondent's company clinic were admitted into evidence as Petitioner's Exhibit 6. They relate a history of bilateral hand cysts among other complaints. (Px6)

On September 16, 2004, Petitioner was seen for an initial visit by Nurse, Judy Burghgrave of Respondent's clinic. Petitioner presented with complaints of numbness and tingling in the ring and little fingers bilaterally, but was most concerned with her left little finger. (Px6) Physical examination revealed full range of motion and tenderness at the tip of the finger. Petitioner was assessed with left little finger numbness. An appointment was made with Dr. Cheryl Peterson for September 20, 2004.

When Petitioner saw Dr. Peterson as scheduled, she received bilateral wrist braces. (Px6) Dr. Peterson felt Petitioner had bilateral hand sprains with mild

paresthesias. On October 4, 2004, the diagnosis was changed to a left hand strain with paresthesias of the fifth digit. It was noted that the pain at the top of the little finger had resolved, and that Petitioner felt better if she did not wear the wrist braces. An EMG/NCV study was recommended to evaluate the left upper extremity. It was performed by Dr. Amod Sureka on October 15, 2004, and revealed normal findings. (Px6)

Petitioner last followed up for her left little finger on October 26, 2004. On that date, her physical examination was within normal limits. Petitioner reported improvement and that the "smashing feeling" was gone.

Petitioner did not lose any time from work as a result of her alleged accident of September 15, 2004.

Petitioner saw Dr. Jeffrey Coe at the request of her attorney. (Px7) Dr. Coe opined that Petitioner sustained repetitive strain injuries as a result of her work duties. (Px7, p.12) Regarding this matter, Dr. Coe believed Petitioner sustained bilateral upper extremity strains. (Px7, p.12)

Petitioner saw Dr. Prasant Atluri at the request of Respondent for a Section 12 examination on April 1, 2013. Dr. Atluri's report was admitted into evidence as Respondent's Exhibit 1. Dr. Atluri opined that Petitioner's complaints of bilateral ring and small finger numbness and tingling was suspicious for cubital tunnel syndrome, but that her electrodiagnostic studies suggested ulnar neuritis rather than an active ulnar neuropathy. (Rx1, p.6) Based upon the information available to Dr. Atluri (the medical records reviewed, the history given by Petitioner and her physical examination findings),

and Petitioner's description of her job duties, Dr. Atluri found Petitioner's complaints of bilateral hand numbness and tingling were not related to her job duties. (Rx1, p.8)

CONCLUSIONS OF LAW

Regarding issue (c) and (f), whether Petitioner sustained an accident that arose out of and in the course and scope of her employment which is causally related to her injuries, the Arbitrator finds as follows:

The Arbitrator notes that Petitioner gave a history of prior problems with both hands when she reported concerns about her left little finger. The medical records of Respondent's Clinic as well as other providers (Px5) relate prior hand complaints including cysts bilaterally. Although Petitioner received diagnoses of hand strains, those conditions does not correlate with, nor explain Petitioner's complaints of "pins and needles" or the "smashing feeling" in her left fifth finger. Even Dr. Atluri's suspected diagnosis of ulnar neuropathy was ruled out by Petitioner's normal electrodiagnostic studies. The Arbitrator struggles to find any specific medical condition to explain Petitioner's complaints.

In addition, this claim was initially reported as involving the fourth and fifth fingers of the Petitioner's left hand. Her work on the sealer deck as a fuel opener involved primarily the right hand and arm. Half her day was spent using a skiver to scrape sealant, and she used her dominant right hand to perform that task. The other half of the day was spent applying sealant, which she squeezed from a tube, again with her dominant right hand.

Her various diagnoses include bilateral neuritis but, as stated above, no doctor related the condition to her work. Even Dr. Coe, her examiner, does not address the condition in his report.

Based upon the above evidence, the Arbitrator finds the Petitioner did not prove an accident arising out of her employment causally related to any injury.

Regarding *issue (j), whether Respondent provided reasonable and necessary medical services, the Arbitrator finds as follows:*

Noting the Arbitrator's findings regarding issue (c) above concerning accident, this point is moot. All claims for benefits are denied.

Regarding issue (l), nature and extent of Petitioner's injuries, the Arbitrator finds as follows:

Noting the Arbitrator's findings regarding issue (c) above concerning accident, this point is moot. Therefore, all claims for benefits are denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jill Murphy,

Petitioner,

vs.

NO. 09 WC 50267

Mitsubishi Motors North America,

15IWCC0010

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, permanent disability, causal connection and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 13, 2014 is hereby affirmed and adopted.

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

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

No bond is required for removal of this cause to the Circuit Court by Respondent.

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

DATED: JAN 9 - 2015
SJM/sj
o-12/4/2014
44

Stephen J. Mathis

Mario Basurto

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MURPHY, JILL
Employee/Petitioner

Case# **09WC050267**

06WC050823
06WC050822
11WC012417

MITSUBISHI MOTORS OF NORTH AMERICA
Employer/Respondent

15IWCC0010

On 5/13/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% 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:

0293 KATZ FRIEDMAN EAGLE ET AL
CHRIS MOSE
77 W WASHINGTON ST 20TH FL
CHICAGO, IL 60602

2461 NYHAN BAMBRICK KINZIE & LOWRY PC
ADAM J COX
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602

15IWCC0010

STATE OF ILLINOIS)
)SS.
COUNTY OF McLean)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Jill Murphy
Employee/Petitioner

v.

Mitsubishi Motors of North America
Employer/Respondent

Case # **09** WC **50267**

Consolidated cases: **06 WC 50822, 06 WC 50823, 11 WC 12417**

An *Application for Adjustment 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 **Bloomington**, on **March 25, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **September 17, 2008**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$57,200.00**; the average weekly wage was **$1,100.00**.

On the date of accident, Petitioner was **46** years of age, *married* with **0** dependent children.

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

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

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

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

ORDER

The Arbitrator finds Petitioner did not sustain an accident arising out of and in the course of her employment on September 17, 2008 which is causally related to her injuries.

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.

D. B. Hall
Signature of Arbitrator

April 30, 2014
Date

MAY 13 2014

15IWCC0010

FINDINGS OF FACT

Petitioner works as an Associate for Respondent. She claims an injury to her shoulder that occurred on September 17, 2008. The Arbitrator notes that Petitioner's Application for Adjustment of Claim lists an accident date of October 1, 2008, but it was amended orally at trial on March 25, 2014.

A Medical Clinic First Report of Injury/Illness was submitted into evidence as Petitioner's Exhibit 3. In it Petitioner reported her neck and shoulder started to hurt after she lifted a hatch lid. (Px3)

On September 17, 2008, Petitioner went to Respondent's company clinic and was seen by Nurse, Rhonda Beard. (Px6, report of 9/17/08) Petitioner complained that her right shoulder and neck hurt when she went to lift a lift and lower a single hatch lid. Petitioner noted past problems with her shoulder and neck, and assessed with a miscellaneous neck condition.

Petitioner was seen at Midwest Orthopedic Center on October 13, 2008 by Dr. Michael Gibbons. (Px5, 10/13/2008 report) At that time, she complained of right shoulder pain that extended into her neck. Petitioner gave a history of a gradual onset of pain since March of 2008, and denied any specific injury. According to Petitioner, she had a lot of trouble reaching behind her. Petitioner also denied any prior injury but thought she was evaluated for similar problems a year earlier.

An MRI of Petitioner's right shoulder performed on October 27, 2008 revealed significant acromioclavicular joint arthrosis with capsular hypertrophy, some tendinopathy, a possible partial thickness supraspinatus tear, and tendinosis of the long head of the biceps tendon. (Px5)

Prior to Petitioner's alleged accident, she underwent an MRI of her right shoulder at Proctor Hospital on September 10, 2002. (Px5) It revealed mild degenerative acromioclavicular joint arthropathy, subacromial subdeltoid bursitis, and mild tendinitis of the rotator cuff. Petitioner's medical records reveal a past medical history of right shoulder tendinopathy and impingement issues since 2002. (Px5)

Following the MRI, Petitioner returned to Dr. Gibbons on November 3, 2008. (Px5) She reported her symptoms were "about the same". Dr. Gibbons found diffuse tenderness in the superolateral and anterior aspects of her shoulder. Diagnoses were rendered of right shoulder rotator cuff tendinopathy with a possible partial tear, acromioclavicular joint arthrosis and myofascial pain. Dr. Gibbons did not recommend surgery and noted that Petitioner "certainly has several reasons why she may have some shoulder pain." She was allowed to continue working as tolerated.

Petitioner was next examined by Dr. Gibbons on December 15, 2008. (Px5) The doctor noted significant improvement, although Petitioner perceived it as old mild in degree and could not rate her symptoms. Petitioner was instructed to follow up as necessary.

Petitioner saw Dr. Jeffrey Coe at the request of her attorney. (Px7) Dr. Coe opined that Petitioner sustained repetitive strain injuries as a result of her work duties. (Px7, p.12) Regarding this matter, Dr. Coe believed Petitioner sustained a right arm and shoulder strain on October 1, 2008.

Petitioner saw Dr. Prasant Atluri at the request of Respondent for a Section 12 examination on April 1, 2013. Dr. Atluri's report was admitted into evidence as Respondent's Exhibit 1. According to Dr. Atluri, Petitioner claimed her right shoulder

symptoms in 2008 began when she attempted to reach to the right and overhead to hand a "gun" (Rx1, pp. 2, 7) Dr. Atluri opined that Petitioner's medical records were suggestive of chronic impingement syndrome, but her examination was relatively benign. (Rx1, p.6) He noted that Petitioner described her job as requiring her to repeatedly reach above and behind her to hand up a tool, but because she did not describe significant lifting at or above shoulder level on a frequent basis, he felt that her shoulder problems were not related to her work duties. Based upon Petitioner's description of her work duties and onset of symptoms, Dr. Atluri opined that Petitioner's right shoulder problems were not related to her work duties. (Rx1, p.7)

CONCLUSIONS OF LAW

Regarding issue (c), whether Petitioner sustained an accident that arose out of and in the course and scope of her employment, the Arbitrator finds as follows:

The Arbitrator finds Petitioner did not sustain a work-related accident on September 17, 2008. The Arbitrator bases this determination on a careful review of the medical evidence and accident report submitted by Petitioner.

The Arbitrator notes that Petitioner had a history of degeneration in her right shoulder dating back to 2002. Comparison of the findings of the MRI of October 27, 2008, support Dr. Atluri's opinion that Petitioner's medical records are suggestive of a chronic underlying condition. There is no suggestion in Petitioner's treating records that she sustained an aggravation or exacerbation of that condition.

The Arbitrator notes that the history of injury given to Dr. Atluri of reaching to the right and overhead for a gun does not match the history in the company clinic records (Px6) or her accident report (Px3). In a light most favorable to Petitioner and using the documents most contemporaneous with the alleged incident, it appears she claims right

shoulder complaints after lifting a hood. This is inconsistent with Dr. Coe's opinion of "overuse syndrome" since Petitioner seems to claim a single incident is responsible for her right shoulder hurting. As a consequence, the Arbitrator finds Dr. Atluri's opinions to be the most persuasive in this matter. Therefore, the Arbitrator agrees with Dr. Atluri that Petitioner's right shoulder complaints are not related to an alleged work accident of September 17, 2008, or even October 1, 2008.

Regarding issue (f), whether Petitioner's current condition of ill-being is causally related to a work injury, the Arbitrator finds as follows:

Noting the Arbitrator's findings regarding issue (c) above concerning accident, this point is moot.

Regarding issue (j), whether Respondent provided reasonable and necessary medical services, the Arbitrator finds as follows:

Noting the Arbitrator's findings regarding issue (c) above concerning accident, this point is moot. All claims for benefits are denied.

Regarding issue (k), whether Petitioner is entitled to temporary total disability benefits, the Arbitrator finds as follows:

Noting the Arbitrator's findings regarding issue (c) above concerning accident, this point is moot. All claims for benefits are denied.

Regarding issue (l), nature and extent of Petitioner's injuries, the Arbitrator finds as follows:

Noting the Arbitrator's findings regarding issue (c) above concerning accident, this point is moot. All claims for benefits are denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jill Murphy,

Petitioner,

vs.

NO. 11 WC 12417

Mitsubishi Motors North America,

15IWCC0011

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 13, 2014 is hereby affirmed and adopted.

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

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

No bond is required for removal of this cause to the Circuit Court by Respondent.

15IWCC0011

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: JAN 9 - 2015
SJM/sj
o-12/4/2014
44

Stephen J. Mathis

Mario Basurto

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

15IWCC0011

MURPHY, JILL
Employee/Petitioner

Case# **11WC012417**

06WC050823
09WC050267
06WC050822

MITSUBISHI MOTORS OF NORTH AMERICA
Employer/Respondent

On 5/13/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% 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:

0293 KATZ FRIEDMAN EAGLE ET AL
CHRIS MOSE
77 W WASHINGTON ST 20TH FL
CHICAGO, IL 60602

2461 NYHAN BAMBRICK KINZIE & LOWRY PC
ADAM J COX
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602

15IWCC0011

STATE OF ILLINOIS)
)SS.
COUNTY OF McLean)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Case # 11 WC 12417

Consolidated cases: 06 WC 50822, 06 WC 50823, 09 WC 50267

Jill Murphy
Employee/Petitioner

v.

Mitsubishi Motors of North America
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 **Douglas McCarthy**, Arbitrator of the Commission, in the city of **Bloomington**, on **March 25, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **February 22, 2010**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did 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 **$49,920.00**; the average weekly wage was **$960.00**.

On the date of accident, Petitioner was **48** years of age, ***married*** with **0** dependent children.

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

Respondent ***has*** 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 for other benefits, for a total credit of **$0**.

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

ORDER

The Arbitrator finds Petitioner did not sustain an accident arising out of and in the course of her employment on February 22, 2010 causally related to her injuries.

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.

D. Ryan McCarthy
Signature of Arbitrator

April 29, 2014
Date

MAY 13 2014

15IWCC0011

FINDINGS OF FACT

Petitioner works as an Associate for Respondent. She claims an injury to her left hand that occurred on February 22, 2010. Petitioner testified that at that time she worked in Respondent's sealer department. She alternated between two jobs for a quarter of each workday. The first job was a "ten and a half", which required her to place stud covers on vehicles. The other position was a line keeper, which required her to fill in for other line workers who took breaks or were otherwise not present. Previously Petitioner did skiving and sealing work for Respondent, but testified that she bid for a job change after she returned to work in May of 2007.

On February 22, 2010, Petitioner reported that she felt stinging and burning in her left wrist while applying stud covers. (Px4) Petitioner indicated that she did not use her left hand as much in her new position, but it still hurt. She also testified at arbitration that her burning in the wrist actually began in December 2009 while performing the above described work. Her accident report, filed on February 22, 2010, says the same thing.

On May 13, 2010, Petitioner went to Dr. Williams, whom she had previously seen for bilateral hand and wrist complaints. (Px5) She complained of a left wrist cyst, and Dr. Williams noted that she previously had one removed from her right side. An MRI was ordered for further evaluation.

The following day on May 14, 2010, Petitioner had an MRI of her left wrist. (Px5) It revealed multiple findings that included, attenuation/thinning of the TFC disc, a thinly septated ccapsulosynovial cyst in the palmar aspect of the TFC disc, another cyst at the tubercle/distal pole of the scaphoid, and mild dorsal wrist capsulitis.

Petitioner received a cortisone injection from Dr. Williams' physician's assistant on May 27, 2010 and her diagnosis was changed to left wrist FCR tendonitis. (Px5) A basilar thumb splint was provided on June 21, 2010.

Petitioner was much improved and reported only an occasional stinging when seen by Dr. Williams on July 19, 2010. (Px5) She was advised to return on an as needed basis.

On December 6, 2010, Petitioner went back to Dr. Williams complaining of tenderness over her FCR tendon. A second cortisone injection was administered.

Petitioner did not return to Dr. Williams until April 25, 2011. At that time, Dr. Williams attributed Petitioner's FCR tendonitis to the presence of a left wrist cyst. (Px5) Surgical excision was recommended and performed on May 17, 2011. (Px5) Petitioner was restricted from work for almost two weeks following surgery. Light duty work restrictions were issued on June 1, 2011, and made permanent by Dr. Williams on June 30, 2011. (Px5)

Petitioner last saw Dr. Williams on August 1, 2011. At that time, the numbness on the top of her thumb had resolved, and she was doing better. The permanent work restriction was related to Petitioner's right hand. On September 11, 2011, Dr. Williams saw no evidence of a recurrence of her left wrist cyst, and told her to return as needed. (Px1-9, Rx1)

Petitioner saw Dr. Jeffrey Coe at the request of her attorney. (Px7) Dr. Coe opined that Petitioner sustained repetitive strain injuries as a result of her work duties. (Px7, p.12) Regarding this matter, Dr. Coe believed Petitioner strained her left hand and wrist. (Px7, p.12)

Petitioner saw Dr. Prasant Atluri at the request of Respondent for a Section 12 examination on April 1, 2013. Dr. Atluri's report was admitted into evidence as Respondent's Exhibit 1. Dr. Atluri believed that there was a chronic component to Petitioner's bilateral wrist conditions, that her bilateral thumb complaints were related to chronic arthritis that was not related to or aggravated by work duties, and that given her multiple normal diagnostic findings the bilateral hand numbness and tingling complaints were unrelated to her work activities. (Rx1, pp.7-8)

CONCLUSIONS OF LAW

Regarding issue (c), whether Petitioner sustained an accident that arose out of and in the course and scope of her employment, the Arbitrator finds as follows:

The Arbitrator finds Petitioner did not sustain a work-related accident on February 22, 2010. The Arbitrator bases this determination on a careful review of the medical evidence and accident report submitted by Petitioner.

Petitioner initially complained of left wrist problems on February 22, 2010, despite using her left hand less frequently since a job change. She said the problems began at work in December 2009. Dr. Williams, or more specifically his physician assistant, diagnosed Petitioner with FCR tendonitis on April 25, 2011, but he said that it was caused by a left wrist cyst, which was subsequently removed. Within approximately 8 weeks of the surgical excision Petitioner no longer had any work restrictions relative to her allegedly injured left hand. Neither Dr. Williams, not any other doctor, provided an opinion that the left wrist ganglion was work related.

The Arbitrator notes that Petitioner has a history of multiple hand/finger cysts developing and being removed since 2003. (Px5, Px6) Dr. Williams did not render any opinion whether the volar carpal ganglion cyst removed on May 17, 2011, or the FCR

tendonitis the doctor believed it caused, were related to Petitioner's alleged work accident of February 22, 2010. Dr. Coe opined that Petitioner sustained a strain on February 22, 2010, which does not comport with the findings of any of the medical treatment records.

It is the Petitioner's burden to prove each and every element of her claim. She failed to do so in this case. The Arbitrator denies that Petitioner sustained a work-related accident on February 22, 2010 due to a failure of proof. All claims for benefits are denied.

Regarding issue (f), whether Petitioner's current condition of ill-being is causally related to a work injury, the Arbitrator finds as follows:

Noting the Arbitrator's findings regarding issue (c) above concerning accident, this point is moot.

Regarding issue (j), whether Respondent provided reasonable and necessary medical services, the Arbitrator finds as follows:

Noting the Arbitrator's findings regarding issue (c) above concerning accident, this point is moot. All claims for benefits are denied.

Regarding issue (k), whether Petitioner is entitled to temporary total disability benefits, the Arbitrator finds as follows:

Noting the Arbitrator's findings regarding issue (c) above concerning accident, this point is moot.

Regarding issue (l), nature and extent of Petitioner's injuries, the Arbitrator finds as follows:

Noting the Arbitrator's findings regarding issue (c) above concerning accident, this point is moot. All claims for benefits are denied.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jill Murphy,

Petitioner,

vs.

NO. 06 WC 50822

Mitsubishi Motors North America,

15IWCC0012

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, permanent 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 May 13, 2014 is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $58,600.00.

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

DATED: JAN 9 - 2015

SJM/sj
o-12/4/2014
44

Stephen J. Mathis

David L. Gore

Mario Basurto

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MURPHY, JILL
Employee/Petitioner

Case# **06WC050822**

06WC050823
09WC050267
11WC012417

MITSUBISHI MOTORS OF NORTH AMERICA
Employer/Respondent

15IWCC0012

On 5/13/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% 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:

0293 KATZ FRIEDMAN EAGLE ET AL
CHRIS MOSE
77 W WASHINGTON ST 20TH FL
CHICAGO, IL 60602

2461 NYHAN BAMBRICK KINZIE & LOWRY PC
ADAM J COX
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602

15IWCC0012

STATE OF ILLINOIS)
)SS.
COUNTY OF McLEAN)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

JILL MURPHY
Employee/Petitioner
v.

Case # 06 WC 50822

Consolidated cases: 06 WC 50823
09 WC 50267; 11 WC 12437

MITSUBISHI MOTORS OF NORTH AMERICA
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 **Douglas McCarthy**, Arbitrator of the Commission, in the city of Bloomington, on March 25, 2014. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **September 19, 2005**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$57,200.00**; the average weekly wage was **$1,100.00**.

On the date of accident, Petitioner was **43** years of age, ***married*** with **0** dependent children.

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

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

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

Respondent is entitled to a credit of $20,162.60 for payments made under Section 8(j) of the Act and also for payments made by BlueCross/BlueShield under Section 8(j) of the Act.

ORDER

- The respondent shall pay the petitioner temporary total disability benefits of $ 733.33/week for 39 weeks, from August 24, 2006 through May 13, 2007, which is the period of temporary total disability for which compensation is payable.
- The respondent shall pay the petitioner permanent partial disability benefits of $ 591.77/week for a further period of 50.6 weeks, as provided in Section 8(e)(10) of the Act, because Petitioner has sustained 20% loss of use of her right arm
- The respondent shall pay to the petitioner for medical expenses as outlined in this decision pursuant to Section 8(a) and 8(2) of the Act. The Respondent shall further hold Petitioner harmless with respect to payments made by the group health carrier, pursuant to 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.

D. D. McCarthy
Signature of Arbitrator

April 30, 2014
Date

MAY 13 2014

JILL MURPHY 06 WC 50822
v.
MITSUBISHI MOTORS NORTH AMERICA

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Petitioner testified that she is right-handed. She has worked for Respondent since 1988 in the manufacture of automobiles. She worked on the Sealer Deck in the paint shop, where she performed two jobs: skiving and fuel opening. She would work at these two jobs over the course of an eight hour day, rotating after two hour blocks.

In the fuel opening job, she would apply sealer from a plastic squeeze bottle that she held in her right hand. She would try to wipe off excess sealer with a cloth held in her left hand.

Skiving involved using a small, flexible plastic tool with a sharp edge to scrape off excess sealer that had been applied to a car. She would pinch the skiving tool with her fingers in the right hand and scrape the sealer off forcefully, and then wipe with a cloth held in her left hand.

On January 12, 2004, Petitioner went to Respondent's medical department and sought treatment for a cyst which had developed on the anterior aspect of her right hand. (Px#6). On August 18, 2004, Petitioner reported to the medical clinic with a contusion and a cyst on the back of her left hand and it was recommended that she apply ice. (Px#6). She sought treatment with orthopedic specialist Dr. James Williams of Midwest Orthopedics on August 20, 2004 and he recommended a surgical excision. Surgery was performed on October 28, 2004 and the cyst was removed. (Px#5).

On September 15, 2004, Petitioner began to feel a pins and needles sensation in the last finger of her left hand when squeezing her rag when wiping sealer off of her fingers. She went to Respondent's medical clinic the next day and completed a First Report of Injury form, where she indicated that she had been having an ongoing problem with the last two fingers on each hand going numb, but had now also experienced pins and needles in the pinky finger of her left hand. (Px#1). She saw the company doctor on September 20th and he diagnosed her with bilateral wrist sprains and recommended an EMG/NCV. (Px#6). The EMG/NCV was found to be normal. (Px#5).

Petitioner also developed a ganglion cyst on the top of her right hand in August 2004. She sought treatment with Dr. James Williams of Midwest Orthopedics and had the cyst removed on October 28, 2004. On February 7, 2005, Dr. Williams released her from care. (Px#5).

Petitioner continued to work in the Sealer Deck at the fuel opening job and the skiving job. On September 23, 2005, she completed a First Report of Injury which stated

that on 9/19/05 she was skiving the upper rear structure of a car when she experienced a pain in her right hand that went into her wrist all the way down to her elbow. (Px#2). X-rays were performed which were normal, and Petitioner was told to use ice and ibuprofen, and she was given a wrist support. (Px#6). Petitioner testified that she could not use the brace because she could not bend her wrist to get into hard to reach places when she was skiving.

She continued to experience pain in her right wrist through the fall and into the first few months of 2006. She underwent another EMG on February 3, 2006 which was found to be within normal limits. On March 17th, Petitioner saw Dr. Tack in Respondent's medical clinic. Dr. Tack noted that she had tenderness along the ulnar border of her wrist and a possible ganglion cyst.

Ms. Murphy stopped working on March 21, 2006 when she underwent treatment for thyroid cancer. She remained off of work while she underwent treatment for this through August 14, 2006. During this time, she continued to experience pain in her right hand, forearm, and elbow. Petitioner recovered from thyroid cancer and was released to return to work on August 14, 2006. She saw Dr. James Williams of Midwest Orthopedics on the same date for her pain in her right forearm and elbow.

The records from Midwest Orthopedics show that Petitioner saw Dr. Williams on August 14, 2006 for right elbow pain along the lateral aspect of the elbow that had been bothering her since the end of March and now the pain is to the point that she can't even sleep. Dr. Williams diagnosed her with lateral epicondylitis, restricted her from using her right arm, and recommended a cortisone shot to the elbow. An MRI was performed on her right elbow which revealed lateral epicondylitis. Dr. Williams recommended she undergo an ultrasound for treatment. (Px#6).

On October 19, 2006, Dr. Williams noted that Petitioner still had pain over her lateral epicondyle which he felt was aggravated by her job duties. He continued to restrict her to no work with her right hand. On November 27, 2006, the doctor noted that she had improved with restrictions but the ultrasound had not been approved. He recommended further conservative care and continued to restrict her from using her right arm at work. On January 8, 2007, he recommended another MRI and altered her restrictions to no reaching, pulling, or pushing more than 5 pounds with her right arm. (Px#5).

Petitioner testified that when Dr. Williams restricted her from working using her right arm on August 14, 2006 that Respondent did not provide her with a light duty job within those restrictions. Nor did Respondent ever provide her with a light duty job by her testimony.

On February 19, 2007, Dr. Williams decided to give Petitioner a second cortisone injection in her elbow. Petitioner testified that this injection definitely helped to decrease her pain. Dr. Williams released Petitioner to return to work on a full duty basis on May 10, 2007. (Px#5).

On September 20, 2007, Petitioner returned to see Dr. Williams. He noted that she was doing much better since she had been moved to another job. He recommended that she stay in this new job on a permanent basis. (Px#5). On April 14, 2008, Petitioner again returned to Dr. Williams due to pain in her right elbow and the outside of her arm. He recommended another MRI of her elbow. This was done and Dr. Williams felt it showed some improvement over the prior studies though it showed there was still inflammation present. (Px#5).

Shortly after her return to work, Petitioner was able to transfer to different jobs in the Sealer Deck. She continued to work in a two-job rotation. One of her jobs was at "Station 10-1/2" where she would lift rear hatches of the Endeavor and then she would apply sealer to the inside. She would also reach for a tool which was located up and behind her while performing this job. The production speed was approximately one car per minute. The other job was a "Linekeeper," which was a kind of roving substitute for co-workers who needed breaks or were unavailable. This allowed her to work at different jobs in the department. She still performed some skiving, but she said that it was never more than an occasional basis, and therefore within her restrictions.

Petitioner subsequently sought medical treatment for an impingement syndrome in her right shoulder and a ganglion cyst in her left wrist. These conditions are the subject of the companion cases which are consolidated with this claim.

Petitioner returned to see Dr. Williams on September 12, 2011. He continued her restrictions on her right upper extremity of only occasional squeezing, pinching, twisting, or turning, and he stated these were permanent. On December 12, 2011, Petitioner saw Dr. Williams again for palmer-sided pain in her left wrist which made it difficult to squeeze, pinch, and grip. The doctor permanently restricted her against lifting more than 10-15 pounds with her left hand which only occasional gripping, squeezing, and pinching. (Px#5).

Petitioner submitted the report of Dr. Jeffrey Coe into evidence. Dr. Coe examined the Petitioner on September 19, 2012. Dr. Coe took a history of Petitioner's work applying sealer and skiving and reviewed her medical records from Respondent's medical facility and from Dr. Williams. In his exam, Dr. Coe concluded that Petitioner had suffered repetitive strain injuries through her work with Respondent that resulted in right lateral epicondylitis and myofascial pain, and which led to permanent restrictions on squeezing, pinching, twisting, turning, and lifting more than 10 to 15 pounds. He noted that she had continuing weakness with flexion because of her elbow condition.

Respondent had Petitioner examined pursuant to Section 12 of the Act by Dr. Prasant Atluri of Hand Surgery Associates. Based upon his examination of the Petitioner and of the medical records, Dr. Atluri concluded that Petitioner developed right lateral epicondylitis based upon the medical records and the MRI findings, though it was possible that she had an intra-articular abnormality or inflammatory arthropathy as a

potential cause of her pain. Dr. Atluri opined that the Petitioner's lateral epicondylitis could be work related. He said that frequent forceful gripping while her elbow was extended and her forearm was pronated could contribute to the development of the condition. (Rx#1).

At the present time, Petitioner testified that her current jobs require her to scuff and tack cars and to use a sanding pad. She is assigned to work on one side of the car and a co-worker is assigned to the other. If she begins to experience any symptoms while working, she will switch with the co-worker in order to vary her job duties.

She testified that Respondent required her to schedule a return appointment with Dr. Williams in May of 2013 for a renewal of her restrictions. She explained that Respondent will not recognize permanent restrictions and therefore requires her to return to the doctor to have him renew her restrictions. She testified that this bill was paid in part by her health insurance with Blue Cross.

She testified that she has recurrent stabbing pain from her right elbow through her forearm to her wrist. This is not always precipitated by activity but usually occurs when she is pulling something and it will fade when she lets go. She notices these pains when pulling on her clothes or when driving, and must frequently switch her hands on the steering wheel due to alternating pain in the right arm and left wrist. If she holds something in her right hand for too long, such as a lunch box, a coat, or supplies she will develop a burning sensation from the right elbow to her wrist that last for a couple of minutes. She estimated that this happens once a day or maybe once a week.

Petitioner testified that she has a horse which she is no longer able to enjoy because of her injuries. She explained that a horse is a large animal and it takes strength to control it it. Because of her physical condition, she lacks the strength to control it and also pulling on it produces pain. As a result, she has been unable to lead it or ride it since her injuries.

Based upon the above, the Arbitrator reaches the following conclusions:

. Petitioner did sustain an accident to her right arm on September 19, 2005. She developed lateral epicondylitis in her right elbow which is causally related to her work with Respondent.

The Petitioner testified that she had worked on the sealer deck for over 20 years prior to September 2005. She spent approximately half of each work day using the skiving tool to scrape sealer off of car parts. She used her right hand to perform the job, and she demonstrated how she would hold the tool with her right elbow extended while pulling it towards her body. When she began having symptoms in early 2004, she went to the plant medical department and gave essentially the same history. (PX 6, 4-14-2004)

Her forearm pain on April 20, 2004 was reported to be of the level where she could not hold onto the skiver. (Id)

As she continued to perform the same job for the rest of 2004 and the first nine months of 2005, the Petitioner would periodically report her symptoms of forearm pain and numbness of the fourth and fifth fingers to medical. She finally reported her problems to the Respondent on September 23, 2005, and continued to treat until going off work for an unrelated medical problem in March 2006. She testified without rebuttal that her right arm symptoms continued, and upon her release in August she was seen by Dr. Williams, an orthopedic surgeon. He diagnosed right lateral epicondylitis on September 21, 2006, and on October 19, 2006 opined that her assembly work had aggravated that condition. (PX 5) Dr. Williams has continued to treat the condition, and suggested that her job had caused her problem and that she should stay off that job on a permanent basis. (Id 9-20-2007)

Both examining physicians relate her condition to her job, and Dr. Atluri based his opinion on the Petitioner's work history which essentially matched her description at arbitration. (RX 1)

Based upon the above evidence, the Arbitrator finds that the Petitioner has proven an accident arising out of her employment as a result of the repetitive overuse of her right arm during her years of work on the sealer deck. Her diagnosed condition of right lateral epicondylitis is causally related to the work activity.

Petitioner is entitled to receive TTD benefits from August 24, 2006 through May 13, 2007. Petitioner was restricted to light duty by Dr. Williams during this time due to her condition of right lateral epicondylitis. Petitioner testified that Respondent did not provide her with light duty work within her restrictions and this was not disputed by Respondent.

Respondent shall therefore pay to Petitioner the sum of $733.33 for a period of 39 weeks for temporary total disability benefits. This amount shall be subject to a credit under Section 8(j) for the payment of $20,162.60 in short term disability benefits.

Petitioner is also entitled to receive $450.30 for medical expense under Section 8(a) of the Act.

The Arbitrator finds that Petitioner's medical treatment with Dr. James Williams was reasonable and necessary to relieve the effects of her injury.

Petitioner's Exhibit #5 contains the medical bills from Midwest Orthopedics. The majority of the bills for treatment of her right elbow were paid by Petitioner's group health insurance. The bills reflect an unpaid balance, however, in the amount of $450.30, including the restriction review performed by Dr. Williams in May 2013. Respondent is liable for these charges and shall pay those charges to the extent allowed by the Fee Schedule to the Petitioner.

With regards to the nature and extent of the disability, the Arbitrator finds that Petitioner has sustained a 20% loss of her right arm, pursuant to Section 8(e)(10) of the Act.

Petitioner developed a chronic injury to her right elbow which has significantly affected her activities. While Dr. Williams did not recommend surgery to treat this condition, it did require two cortisone injections. More importantly, the injury has resulted in both pain and profound limitations on the Petitioner. She was unable to work for an extended period of time when the condition was in its acute phase and had to bid on a different job after she returned to work. She has permanent restrictions on her activity. Not only is her work affected, but her daily activities at home produce pain as well.

At the time of this date of injury, Section 8(e)(10) of the Act placed the value of an arm at 253 weeks. 20% loss of right arm therefore equals 50.6 weeks.

4-30-14
Date

D. Ryan McCarthy
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

Patricia Escobar,

Petitioner,

vs.

NO. 09 WC 28266

15IWCC0013

Portillo's Hot Dogs,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issue of reinstatement and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator to deny reinstatement.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 11, 2014 is hereby affirmed and adopted.

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

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

No bond is required for removal of this cause to the Circuit Court by Respondent.

15IWCC0013

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: JAN 9 - 2015
SJM/sj
o-12/4/2014
44

Stephen J. Mathis

David L. Gore

Mario Basurto

STATE OF ILLINOIS)
) SS.
COUNTY OF KANE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jorge Aguilar,
Petitioner,
vs.

NO: 12WC 28113
15IWCC0014

Sealy Corporation,
Respondent,

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 11, 2014 is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $43,653.52. 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: JAN 12 2015
MJB/bm
o-01/06/15
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

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

AGUILAR, JORGE
Employee/Petitioner

Case# **12WC028113**

15IWCC0014

SEALLY CORPORATION
Employer/Respondent

On 4/11/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% 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:

1228 KINNALLY FLAHERTY KRENTZ & LORAN PC
MICHAEL W LOREN
2114 DEERPATH RD
AURORA, IL 60506

2355 JOSEPH R NAVARRO LAW OFFICE
116 W LaFAYETTE ST
SUITE 2
OTTAWA, IL 61350

4866 KNELL O'CONNOR DANIELEWICZ PC
ROBERT M HARRIS
901 W JACKSON BLVD SUITE 301
CHICAGO, IL 60607

15IWCC0014

FINDINGS

On the date of accident, **1/3/12**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$47,183.24**; the average weekly wage was **$907.37**.

On the date of accident, Petitioner was **32** years of age, ***single*** with **no** dependent children.

Respondent ***has*** paid all reasonable and necessary charges for all reasonable and necessary medical services to date. At issue is prospective medical treatment that has not yet been incurred.

Respondent shall be given a credit of **$4,839.28** for TTD, **$6,761.49** for TPD, **$0.00** for maintenance, and **$0.00** for other benefits, for a total credit of **$11,600.77**.

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 $604.91 per week for 80 weeks, commencing 7/11/12 through 1/21/14, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from 1/4/12 through 1/21/14, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall be given a credit of $4,839.28 for temporary total disability benefits that have been paid.

Petitioner is entitled to prospective medical treatment in the form of surgery prescribed by Dr. Rabin consisting of a microdiscectomy at L4-5 and L5-S1, and Respondent shall pay the reasonable and necessary medical expenses associated therewith, as provided in §§ 8(a) and 8.2 of the Act.

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

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

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

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

Signature of Arbitrator

4/4/14
Date

ICArbDec19(b)

APR 11 2014

STATE OF ILLINOIS)
)SS.
COUNTY OF KANE)

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

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

Jorge Aguilar,
Employee/Petitioner

v.

Sealy Corporation,
Employer/Respondent

Case # 12 WC 28113

Consolidated cases: none

15IWCC0014

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Peter M. O'Malley**, Arbitrator of the Commission, in the city of **Geneva**, on **1/21/14**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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 _____

STATEMENT OF FACTS:

Petitioner testified in English (TX, pg. 9). He had been working for Respondent as a machine operator when he was injured on January 3, 2012 (TX, pg. 12). As a machine operator, Petitioner was responsible for lifting and pulling racks full of panels, each weighting approximately 20 to 40 pounds (TX, pgs. 10-11). He was required to lift and stack the panels and he described his job as very physically demanding (TX, pgs. 11-12).

The accident is not in dispute. The evidence establishes that Petitioner was at work when panels on a tall cart began to fall. He attempted to help a co-worker and prevent the panels from falling to the floor by supporting the panels with both hands slightly above shoulder level (TX, pgs. 12-13, 30, PX 3). He was also slightly side bent to his right (PX 3). The panels were in Petitioner's hands when he felt the pain in his lower back, including a stretching or pulling sensation which he had never felt prior to the work accident (TX, pgs. 14-15, 30-31). He immediately reported the injury to his supervisor, Victor Madrigal, and was sent to Tyler Medical Services (TX, pg. 15).

The January 3, 2012 records of Dr. Robert Long of Tyler Medical Services (PX 3) show Petitioner had noted back pain since the time of the accident (PX 3). He was asymptomatic up until the injury (PX 3). On that date, Dr. Long placed Petitioner on restrictions, including no lifting more than ten pounds (PX 3). Dr. Long prescribed up to eight (8) sessions of physical therapy for Petitioner on January 12, 2012 due to continued complaints of low back pain (PX 3). On January 17, 2012, Petitioner advised Dr. George Pappas of Tyler Medical Services that a few hours after his initial physical therapy session on January 16, 2012, he began experiencing tightness and pain radiating from the lower back into the groin and down the left leg with a feeling of numbness in the leg (PX 3). On January 20, 2012, Dr. Long ordered an MRI of the lumbar spine (PX 3). Dr. Patrick F. Para, a board certified diagnostic radiologist with Associated Imaging Specialists, opined that the January 24, 2012 MRI revealed disc protrusion at L4-5 associated with an annular tear and central disc protrusion at L5-S1. On January 26, 2012, Dr. Long referred Petitioner to Dr. Matthew Ross, a board certified neurosurgeon, for further evaluation of his low back and left leg pain (PX 3 and PX 5).

On February 1, 2012, Petitioner saw Dr. Ross (PX 5). On that date, Petitioner told Dr. Ross that his low back pain had not resolved after the physical therapy at Tyler and that he continued to notice a feeling of numbness down to the left knee level (PX 5). Dr. Ross opined that the January 24, 2012, MRI demonstrated a small herniation at L4-5 with an associated annular tear and a central disc herniation at L5-S1 (PX 5). Dr. Ross initially recommended a course of epidural cortisone injections in conjunction with additional physical therapy and continued the same work restrictions for Petitioner (PX 5).

Petitioner subsequently saw Dr. Ross on two more occasions through April 23, 2012. During his treatment with Dr. Ross, Petitioner was referred to Dr. Ryan Brinka for chiropractic treatment and Dr. James Kelly for epidural cortisone injections (PX 5, 6, and 7). Petitioner received a total of eight chiropractic treatments with Dr. Brinka from April 4, 2012 until April 19, 2012 (PX 6). Petitioner testified that the treatment provided by Dr. Brinka only temporarily relieved his pain and he continued to experience the same low back pain shortly after the treatments (TX, pgs. 21-22).

Petitioner further saw Dr. Kelly from DuPage Pain Center for a total of four visits from May 1, 2012 through June 12, 2012 (PX 7). On May 29, 2012, Dr. Kelly performed a lumbar epidural steroid injection on Petitioner (PX 7). Petitioner testified that the injection did not help relieve his pain (TX, pgs. 23 and 51).

Petitioner next saw Dr. Michael Rabin, a board certified neurosurgeon on July 6, 2012 (PX 1, PX 2, pg. 5). Petitioner was referred to Dr. Rabin by a family member (TX, pg. 54). On that date, Dr. Rabin reviewed

numerous records of Petitioner, including, but not limited to, the January 24, 2012 MRI performed at Associated Imaging Specialists and the records of Dr. Matthew Ross (PX 1, PX 2, pgs. 7-8). After reviewing these records, Dr. Rabin obtained a history from Petitioner and performed a neurologic examination (PX 1, PX 2, pgs. 9-10).

At the July 6, 2012 visit, Petitioner complained of back pain that was going down into his left leg (PX 1, PX 2, pg. 11). Having obtained Petitioner's history and performing a neurologic examination, reviewing the reports, records, and various diagnostic studies of Petitioner, Dr. Rabin's diagnosis was that Petitioner had two disc herniations; one at L5-S1, the other at L4-5 (PX 1, PX 2, pg. 12). Based upon the continued complaints of Petitioner and the failed prior conservative management, Dr. Rabin recommended surgery consisting of a microdiscectomy at L4-5 as well as L5-S1, both on the left side, which would include taking some bone off, freeing the nerve up, and if appropriate, taking the disc out (PX 1, PX 2, pgs. 12-13). Dr. Rabin further placed Petitioner on restrictions including that Petitioner work on even surfaces, no use of his feet for pedals, no lifting over ten pounds, and frequent position changes (PX 1, PX 2, pgs. 13-14).

Dr. Rabin opined, based upon a reasonable degree of medical and surgical certainty, that the two disc herniations he diagnosed and treated in Petitioner were caused by the January 3, 2012 work accident based upon Petitioner's absence of back pain before the accident (PX 2, pg. 16-17). Dr. Rabin further opined that the treatment prescribed and rendered by various physicians through July 6, 2012 for Petitioner's back conditions of ill-being was reasonable and necessary and caused by the January 3, 2013 accident (PX 2, pgs. 18-19). Moreover, Dr. Rabin opined that Petitioner will require future medical care and treatment as a result of the January 3, 2012 accident (PX 2, pg. 20). Dr. Rabin noted that the fact that there are no noted complaints of radicular pain in Petitioner's chiropractic records did not change his opinions as radicular pain can wax and wane with disc herniations (PX 2, pgs. 22-23). In addition, Dr. Rabin opined that the fact that Petitioner did not complain of radicular pain until two weeks after the accident is not uncommon as there are several reasons why this might occur (PX 2, pgs. 22-23).

At the request of Respondent, Petitioner was examined by orthopedic surgeon Dr. Steven Mather on August 23, 2012 for purposes of a §12 examination. Dr. Mather testified by way of evidence deposition on August 16, 2013 and October 4, 2013. (RX 1 & RX 2). As noted on the record, the arbitrator denied Petitioner's request to strike the second deposition, which was needed to conclude Dr. Mather's testimony. (TX, pgs. 83-103). Dr. Mather reviewed various records and reports as well as the actual MRI images of the lumbar spine. Upon physical examination, Dr. Mather noted positive Waddell findings and the absence of radiating symptoms down either leg upon straight leg raising. However, Dr. Mather did agree that it would not be abnormal for Mr. Aguilar to not experience radicular complaints until two weeks later if he sustained a disc herniation on January 3, 2012 (RX 1, pgs. 65-66). In any event, Dr. Mather indicated that Petitioner's subjective complaints could not be validated by the MRI or physical examination. Dr. Mather's diagnosis was thoracic and lumbar strain, degenerative disk disease and a component of functional overlay. Dr. Mater also opined that the patient's subjective complaints are not causally related to the accident or pre-existing degenerative conditions. As a result, Dr. Mather was of the opinion that surgery was not warranted and that Petitioner could return to work without any restrictions.

Petitioner testified that he currently still has the same kind of back pain every day. He noted that he starts feeling the pain as soon as he wakes up, and that his level of pain varies from around three or five to seven to nine, based on his level of physical activity. (TX, pgs. 24-25). He also indicated that he still experiences pain and numbness that radiates from his back into his left leg, from his hip down to his knee, which he said comes and goes. (TX, pg. 25). He noted that the pain prevents him from doing "basically everything", including shoveling snow, lifting heavy boxes and vacuuming. (TX, pg. 28). Petitioner also testified that he had never sustained a back injury prior to the accident in question, and that he has not suffered any other injuries involving

his back since. Finally, he indicated that he would like to go ahead with the surgical recommendation made by Dr. Rabin "[j]ust because the choices I got without the surgery are none for living with the pain which I don't want to." (TX, pg. 29).

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 evidence shows that Petitioner suffers from two disc herniations, one at L4-5 and the other at L5-S1. Dr. Para, a board certified diagnostic radiologist opined that the January 24, 2012 MRI revealed disc protrusion at L4-5 associated with an annular tear and central disc protrusion at L5-S1. Furthermore, two board certified neurosurgeons, Dr. Ross and Dr. Rabin, both had an opportunity to review the January 24, 2012 MRI report and films and agree with Dr. Para's opinion that Petitioner has two disc herniations. The only doctor who disagrees with this diagnosis is Respondent's §12 examining physician, Dr. Mather.

The evidence further shows that Petitioner had never sustained a back injury prior to January 3, 2012 and that he has not had any other work accidents or injuries involving his back since January 3, 2012. There is also no evidence that Petitioner had ever suffered any back pain prior to January 3, 2012. On the date of the undisputed accident Petitioner felt an immediate onset of low back pain after reaching overhead in an attempt to prevent a stack of panels, each weighing approximately 20 to 40 pounds, from falling.

Dr. Rabin testified that this can be a common mechanism for disc herniation (PX 2, pg. 18). Even Dr. Mather, in a letter dated July 17, 2013, initially opined that "[g]iven the mechanism of injury reported by the practitioner, it is possible that the January 24, 2012 MRI findings were causally related to the January 3, 2012 accident. However, disc protrusions can be caused by a variety of activities of daily living as well." (PX 9). In that same letter, however, Dr. Mather goes on to opine that Petitioner's subjective complaints were not causally related to the accident or his pre-existing degenerative conditions. (PX 9).

Based on the above, and the record taken as a whole, the Arbitrator finds that Petitioner's current condition of ill-being with respect to his lumbar spine is causally related to the accident on January 3, 2012. Specifically, the Arbitrator finds that Petitioner sustained an aggravation of his pre-existing degenerative condition on the date in question, and that his current need for ongoing treatment is causally related to said work related accident. Along these lines the Arbitrator finds the opinions of treating physician Dr. Rabin to be more persuasive than those offered by Respondent's §12 examining physician, Dr. Mather.

WITH RESPECT TO ISSUE (K), IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner testified that he currently experiences daily back pain with periodic radicular pain and numbness in his left leg which prevents him from performing many activities, including lifting heavy objects, shoveling and vacuuming (TX, pgs. 24-28). Petitioner's level of pain varies based upon his level of activity and is typically a three to five out of ten but can increase to a seven to nine out of ten on his worst days (TX, pg. 25). Petitioner wants to undergo surgery so that he does not have to continue to live in constant pain (TX, pg. 29).

Based on the above, and the record taken as a whole, and in light of the Arbitrator's determination as to causation (issue "F", supra), the Arbitrator finds that Petitioner is entitled prospective medical treatment in the form of surgery recommended by Dr. Rabin – namely, a microdiscectomy at L4-5 and L5-S1. For his part, Dr. Rabin opined that given the fact that conservative measures have failed and in light of

Petitioner's continuing complaints of pain, surgical intervention is medically necessary. (PX2, pp.12-13). Along these lines the Arbitrator finds the opinions of treating physician Dr. Rabin to be more persuasive than those offered by Respondent's §12 examining physician, Dr. Mather.

WITH RESPECT TO ISSUE (L), WHAT AMOUNT OF COMPENSATION IS DUE FOR TEMPORARY TOTAL DISABILITY, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner was taken off work on July 11, 2012. Dr. Rabin has continued to impose restrictions upon Petitioner's ability to work as a machine operator. Dr. Rabin also noted that Petitioner has not reached maximum medical improvement. (PX2, pg. 22).

Therefore, based on the above, and the record taken as a whole, and in light of the Arbitrator's determination as to causation (issue "F", supra), the Arbitrator finds that Petitioner was temporarily totally disabled from July 11, 2012 through January 21, 2014, the date at arbitration, for a period of 80 weeks.

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

Makeisha Luckett,

Petitioner,

vs.

NO: 10 WC 32452
10 WC 32453

15IWCC0015

Behr Process Corporation,

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, causal connection, prospective medical expenses, temporary total disability, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 8, 2014, 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

15IWCC0015

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 $5,700.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JAN 12 2015
TJT:yl
o 12/16/14
51

Thomas J. Tyrrell

Kevin W. Lamborn

Michael J. Brennan

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

LUCKETT, MAKEISHA
Employee/Petitioner

Case# **10WC032452**

10WC032453

BEHR PROCESS CORPORATION
Employer/Respondent

15IWCC0015

On 4/8/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% 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:

0307 ELFENBAUM EVERS & AMARILIO
IAN ELFENBAUM
940 W ADAMS ST SUITE 300
CHICAGO, IL 60607

1153 MARTIN, PATRICK W
203 N LASALLE ST
SUITE 2100
CHICAGO, IL 60601

15IWCC0015

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)

MAKEISHA LUCKETT,
Employee/Petitioner

v.

BEHR PROCESS CORPORATION,
Employer/Respondent

Case # **10** WC **32452**

Consolidated cases: **10 WC 32453**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Lynette Thompson-Smith**, Arbitrator of the Commission, in the city of **Chicago**, on **February 20, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [ ] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [ ] Were the 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 [x] 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, February 24, 2010, Respondent *was* operating under and subject to the provisions of the Act.
- On this date, an employee-employer relationship ***did*** exist between Petitioner and Respondent.
- On this date, Petitioner did sustain an accident that arose out of and in the course of her employment.
- Timely notice of this accident was given to the Respondent.
- Petitioner's current condition of ill-being is causally related to the accident.
- In the year preceding the injury, Petitioner earned **$27,872.00**; the average weekly wage was $536.00.
- On the date of accident, Petitioner was **34** years of age, single, with **4** 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.
- The Respondent shall be given a credit of $23,685.87 for TTD, $0.00 for TPD, $36,345.56 for maintenance and $0.00 for other benefits, for a total of $60, 031.43.
- 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 $357.33 per week for 82 weeks, from August 4, 2010 through July 5, 2011 and from June 28, 2013 through February 20, 2014; and maintenance benefits of $357.33 per week for 101 5/7 weeks, from June 6, 2011 through October 29, 2012 and November 10, 2012 through June 27, 2013, pursuant to Sections 8(a) and 8(b) of the Act.

Respondent shall pay for the reasonable and necessary surgery and post-operative medical care as delineated by Dr. Spencer and provided by Section 8(a) of the Act.

Respondent shall be given a credit of $23,685.87 for temporary total disability paid to Petitioner as provided in Section 8(b) of the Act.

Respondent shall be given a credit of $36,345.56 for maintenance paid to Petitioner, provided by Section 8(a) of the Act.

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

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

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

15IWCC0015

LUCKETT, MAKEISHA
Employee/Petitioner

Case# **10WC032453**
10WC032452

BEHR PROCESS CORPORATION
Employer/Respondent

On 4/8/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% 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:

0307 ELFENBAUM EVERS & AMARILIO
IAN ELFENBAUM
940 W ADAMS ST SUITE 300
CHICAGO, IL 60607

1153 MARTIN, PATRICK W
203 N LASALLE ST
SUITE 2100
CHICAGO, IL 60601

Makeisha Luckett
10 WC 32452
10 WC 32453

15IWCC0015

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)

MAKEISHA LUCKETT,
Employee/Petitioner

v.

BEHR PROCESS CORPORATION,
Employer/Respondent

Case # **10** WC **32453**

Consolidated cases: **10 WC 32452**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Lynette Thompson-Smith**, Arbitrator of the Commission, in the city of **Chicago**, on **February 20, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

B. ☐ 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

15IWCC0015

FINDINGS

- On the date of accident August 3, 2010, Respondent was operating under and subject to the provisions of the Act.
- Timely notice of this accident was given to the Respondent.
- Petitioner's current condition of ill-being is causally related to the accident.
- 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.
- In the year preceding the injury, Petitioner earned $27,872.00; the average weekly wage was $536.00.
- On the date of accident, Petitioner was 34 years of age, with 4 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 $23,685.87 for TTD, $0.00 for TPD, $36,345.56 for maintenance and $0.00 for other benefits, for a total of $60, 031.43.
- Respondent is entitled to a credit of $0.00 under Section 8(j) of the Act.

ORDER

PLEASE REFER TO CASE NUMBER 10 WC 32452.

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

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

FINDINGS OF FACT

Petitioner's Work History and Job Duties

Makeisha Luckett, (the "Petitioner") testified that she was hired in 2005, by Behr Process Corporation (the "Respondent") a paint manufacturer and distributor. After passing a pre-employment physical and drug test, she began working in the distribution division as a reach truck and forklift operator, pulling paint orders for various retail customers such as Home Depot. This involved lifting five-gallon buckets of paint as well as cases, containing four one-gallon buckets. She would then stack the product on pallets and load them using a forklift.

In 2007, the Petitioner received an award from the Respondent for pulling one million pounds of paint orders in a single month. Respondent's company newsletter featured a picture of the company president and vice-president presenting this award along with an article explaining that Petitioner was the first female employee to meet this production goal. PX11.

In 2008, the Petitioner transferred to a new position as a "receiving operator" in the Respondent's manufacturing division. She testified that the new job offered a higher hourly rate and a "new challenge." It also involved more heavy lifting, requiring Petitioner to pull bags of raw material weighing 50-65 pounds for production departments. She estimated that about 60% of the job involved driving a forklift and 40% involved manual labor.

Petitioner testified that she had no history of back injury, and had never been under medical care for her back prior to February 24, 2010.

February 24, 2010 (10WC 32452)

The disputed issues in this matter are: 1) causal connection; 2) temporary total disability; 3) maintenance benefits; and 4) prospective medical care. *See,* AX1.

The Petitioner testified that she was at work on the morning of February 24, 2010, when a supervisor, Tracy Cybolski, arrived at the plant with a supply of rock salt in the back of a pickup truck, and called for her to help unload the salt. This was not one of Petitioner's usual job duties; however, she testified that it was a direct request from a supervisor and one she could not refuse, without being insubordinate. The salt was in fifty-pound sacks. After pulling the fourth or fifth sack of salt from the truck, Petitioner felt a sharp pain in the left side of her back, extending down her left leg all the way to her foot. The pain was intense enough to cause her to stop working. She informed her supervisor, Tracy Cybolski, at the break, and was sent to Advocate Occupational Health ("Advocate").

Petitioner was examined at Advocate by Dr. Settecase, who noted "low back pain radiates into legs after lifting 50 lb bags of salt @work". He also noted that Petitioner smoked one-half (½) pack of cigarettes per day, exercised regularly and coached basketball. Dr. Settecase diagnosed a lumbar sprain, prescribed medication, restricted Petitioner to seated work with minimum walking; and a five-pound lifting limit. Petitioner testified that she went straight home from the clinic and rested. PX6 p. 24-26.

Initial medical treatment and light-duty work restrictions

The next morning she returned to work where her employer assigned her office work. However, she testified that she soon developed painful back spasms, which became unbearable. She was sent via ambulance from the plant to St. James Hospital's emergency room Petitioner reported back pain at a level of 10/10, which began after lifting heavy sacks at work the day before. She was treated with Norco and Flexeril and released. The next day she returned to Advocate and was again assigned sedentary work restrictions. Dr. Settecase noted low back pain radiating to the left buttock and prescribed Vicodin, as her pain was not being alleviated by Mobic. PX 6, p. 23; PX 7, pgs. 8, 12.

Petitioner testified that she returned to a light-duty, seated assignment in the label room. She continued treatment at Advocate, which consisted of medications and physical therapy. The doctor at Advocate advised her to stand up or change positions regularly to avoid back spasms. On April 10, 2010, she was released by the doctors at Advocate to drive a sit-down forklift; but not a reach truck. She continued to have low back pains, radiating down her left leg, which were eased somewhat, by electrical stimulation and physical therapy. PX6, p. 16.

On June 10, 2010, Dr. Payne, at Advocate, noted that Petitioner's pain had increased to a 6/10 level, and that she had not had physical therapy for the past two weeks, due to insurance issues. On June 15, 2010, Dr. Payne ordered a lumbar MRI due to Petitioner's unresolved back pain. The MRI, performed July 1, 2010, showed a left-sided disc herniation at L5-S1 with compression of the thecal sac and the left S1 nerve root sleeve. Upon reviewing the MRI, Dr. Payne referred Petitioner to orthopedic surgeon Patrick Sweeney, M.D. PX2, p. 22; PX6, pgs. 10-13.

On July 29, 2010, Petitioner consulted Dr. Sweeney, who noted a history of low back pain extending down the left leg that began with a heavy lifting injury at work. He found a positive straight-leg raise sign on the left. In reviewing the MRI, he concurred with the diagnosis of a disk herniation and opined that Petitioner was "functioning pretty well despite her ongoing pain" which was characterized as "constant." He referred her to Dr. Jalaja Piska for epidural steroid injections. The Petitioner testified that her low back pain was "awful" at that point, but that she was continuing to work light duty driving a forklift. PX2, pgs. 17-18.

August 3, 2010: (10WC 32453)

The disputed issues in this matter are: 1) accident; 2) notice; 3) causal connection; 4) temporary total disability; 5) maintenance; and 6) prospective medical care. *See,* AX2.

On August 3, 2010, while using the forklift to unload a truck at work, the Petitioner drove over a dock plate while exiting the truck trailer. She testified that she felt a bump and a jostling motion on her forklift truck, accompanied by immediate sharp pain and tingling sensations in her back.

She testified that at that point, she reported to her supervisor, Ms. Cybolski, that she could not continue to drive the truck due to pain, and was sent to Advocate, where she was examined by Dr. Payne. He noted an "exacerbation of pain after forklift shifted this AM." Petitioner's pain level had increased to 9/10 and she was unable to sit for the examination. Dr. Payne took her off work and noted she was already scheduled to see Dr. Piska in two days, for an injection. PX6, p. 9.

Petitioner saw Dr. Piska on August 5, 2010, who diagnosed lumbar nerve root irritation and related this condition to her work accident of February 24, 2010. He prescribed a left-sided epidural steroid injection at L5-S1, which was performed on August 9, 2010. The Petitioner testified that it temporarily helped her pain.

Surgical recommendation, second opinion; and Petitioner's independent medical evaluation

On August 19, 2010, Dr. Sweeney recommended surgery, consisting of a laminectomy and diskectomy at L5-S1. Respondent's workers' compensation carrier approved this surgery.

Petitioner testified that on the advice of her attorney at the time, she sought a second opinion from orthopedic surgeon Alexander Ghanayem, M.D., on November 3, 2010. Like Drs. Sweeney, Piska and the Advocate staff, Dr. Ghanayem recorded a history of a lifting accident at work, with no other significant history, and diagnosed an L5-S1 herniated disc. However, he opined that further conservative care would better serve Petitioner's needs than proceeding with surgery; and referred her to pain specialist Dr. Prempreet Bajaj. PX5, p. 2.

Petitioner began treating with Dr. Bajaj, who performed an epidural steroid injection in December 2010. On January 12, 2011, she returned to Dr. Ghanayem, who noted that at that point, her low back pain was her most prevalent problem, with "an occasional zinger" down her left leg. Dr. Ghanayem again opined that surgery was of limited value in such a case, and referred her back to Dr. Bajaj for further pain management, including possible facet injections. In March 2011, Dr. Bajaj performed a first series of lumbar facet joint injections. On May 4, 2011, he noted that the injections had provided partial pain relief for about five weeks and prescribed a second round of injections, performed in June 2011 PX5, pgs. 14, 23-24, 32, 43 & 56.

On April 13, 2011, at Respondent's request, Petitioner was examined by Dr. Daniel Troy, pursuant to Section 12 of the Act. An addendum to his report was offered May 11, 2011. Dr. Troy recorded a

seven-year work history with Respondent and a lifting injury in February 2010, resulting in low back and left leg pain. He reviewed her MRI and agreed it showed a moderate disk herniation at L5-S1, with some compression of the thecal sac and left S1 nerve root. Dr. Troy also noted a series of steroid injections, including one in the past month. He described her left leg pain as "resolved" and her low back pain as "50% improved." RX1 & 2 pgs. 2, 4.

Dr. Troy agreed that Petitioner could not perform her pre-injury duties and imposed work restrictions. He also prescribed further treatment including lumbar facet injections. However, he opined that Petitioner's work injury had resulted only in a simple lumbar strain, and that her current symptoms and need for treatment were not related to that injury. Rather, they resulted from "pre-existing, advanced, degenerative disk disease" which he concluded had predated the work injury. He cited Petitioner's weight, which at 5'4" should be around 120 pounds in his opinion, but was currently at 278; and her smoking history as causal factors. He also noted, "the patient is 14 months out from her original injury and in my opinion she is in excess." Petitioner testified that Respondent continued to provide medical care and TTD following Dr. Troy's examination. RX1, p. 4-5; RX 2.

Permanent restrictions and job search

On June 28, 2011, Petitioner completed a functional capacity evaluation ("FCE") at ATI Physical Therapy. This was judged to be valid, with maximum effort on her part; and placed her at a light work level. This was below the demands of her regular work, which was judged as medium with lifting up to fifty (50) pounds. She was given specific restrictions of occasional lifting up to seventeen (17) pounds, with limited bending; and sustained standing or sitting limited to thirty-minute intervals. PX4.

On July 5, 2011, Petitioner saw Dr. Bajaj for a final time, who prescribed permanent work restrictions, as indicated in the FCE report. He noted that she continued to have chronic, low back pain and would need ongoing help with pain management; however, he also opined that further injections or physical therapy were unlikely to help, and that he had little to offer her in the future, as treatment. Dr. Bajaj therefore released Petitioner from his care. PX5, pgs. 66-67.

Petitioner testified that soon after that time, she began a search for alternate work within her restrictions, with the assistance of Respondent's vocational rehabilitation consultant. She submitted numerous applications, prepared a resume, kept a job search log and attended several job fairs. Petitioner did briefly secure work, through a temporary agency, in the fall of 2012. She worked as a quality-control inspector, a job she could perform in a sitting position. That job ended after two weeks and she was not offered any further assignments. PX10.

Petitioner testified that throughout this time, , she was still affected by chronic, low back and left leg pain, which limited her daily activities. She tried to manage the pain with ibuprofen and rest. On one occasion in November 2012, she sought care at St. Joseph's Hospital's emergency room for a flare-up

of back and leg pain. The lumbar MRI she was given at St. Joseph's indicated a moderate broad-based posterior disk bulge at L5-S1 along with a "vacuum phenomenon" at that level. PX9.

Dr. Spencer recommends fusion; Petitioner's second independent medical examination and termination of TTD

Petitioner testified that she continued to be frustrated by her ongoing symptoms and when a family friend reported being greatly helped by back surgery with Dr. David Spencer, she requested an appointment. Respondent agreed to authorize and pay for this consultation, completed April 17, 2013; as well as the follow-up MRI ordered by Dr. Spencer. Dr. Spencer opined that her ongoing symptoms were related to the disk herniation caused by her lifting injury at work. PX1, p. 1.

The MRI, performed June 21, 2013, was read to showed a moderate, diffused, posterior disk bulge with a small herniation into the left foramen. Petitioner returned to Dr. Spencer on June 27, 2013, when he reviewed her MRI and found that the L5-S1 disk was herniated and substantially reduced in size; and that Petitioner still had severe disk degeneration at that level. Given these findings and the predominance of low back pain over sciatic pain in the left leg, Dr. Spencer recommended spinal fusion surgery. PX1, p. 3.

On July 15, 2013, Petitioner's vocational rehabilitation services were terminated, at the request of Respondent's insurance carrier, due to Dr. Spencer's surgical recommendation. The respondent also arranged for her to be re-evaluated by Dr. Troy, pursuant to Section 12 of the Act. PX10, p. 121.

On October 1, 2013, Dr. Troy re-examined the petitioner and reviewed the recent MRI findings. He concurred with Dr. Spencer's recommendation for spinal fusion surgery to address Petitioner's ongoing symptoms. However, Dr. Troy reiterated his opinion that the injury had produced only a lumbar strain, which had long since resolved, returning Petitioner "to her pre-injury status." Petitioner's current symptoms, he opined, were part of the "natural progression" of her pre-existing degenerative disk disease, which was rooted in her morbid obesity and smoking. Dr. Troy noted Petitioner's weight as 238 pounds; his initial examination, in 2011, had recorded a weight of 278 pounds. However, he did not take note of Petitioner's weight loss or its impact, if any, on her low back pain. Dr. Troy further opined that she "could have had a long standing herniation that was present prior to her lumbar strain" and that a link between her accident and the disk protrusion on her MRI had not been proven. Finally, he alleged that her radicular leg symptoms had not been present at the time of her injury and had only emerged "sometime later." Based on Dr. Troy's report, on November 2, 2013, the Respondent discontinued TTD benefits and denied liability for any further medical care. RX3, pgs. 6-8.

Petitioner's current condition and Dr. Spencer's narrative report

Petitioner testified that she continues to experience disabling back and leg pain, which has never resolved since the work injury in 2010. She testified that her pain, which often flares-up in the form of a "charley horse" or spasm, interferes with housework and other activities of daily living. Her back spasms return if she sits or stands continuously for more than about thirty (30) minutes. Her four children, ages ten through fifteen, help her with grocery shopping and similar chores.

Petitioner testified that she has lost almost sixty pounds since her back injury and that she made this effort in response to Dr. Troy's admonitions that her obesity was contributing to her back pain. She has also limited her smoking to about three cigarettes per day. However, she testified that these measures had not really improved her symptoms. She testified that she was anxious to have the surgery prescribed by Dr. Spencer in order to relieve her symptoms and enable her to return to a more active life, including working.

On January 7, 2014, Dr. Spencer authored a narrative report regarding his diagnosis and surgical recommendation. Dr. Spencer found that the protruding material from Petitioner's herniated lumbar disk has been partially re-absorbed, in the three years since her injury; however, she now presents with a severely degenerated L5-S1 disk, resulting in chronic back and leg pain. Dr. Spencer explained that because of the time elapsed since Petitioner's injury, the surgical procedure originally recommended by Dr. Sweeney, namely a microdiscectomy, would now have little chance of improving her symptoms. Instead, he recommended a surgical fusion at L5-S1 as her best option. Dr. Spencer opined that Petitioner's current symptoms, and her need for the fusion surgery, were "completely related" to the original lifting injury in 2010. PX1, p. 6.

CONCLUSIONS OF LAW

C. Did an accident occur which arose out of and in the course of Petitioner's employment with Respondent?

A claimant has the burden of proving, by a preponderance of the evidence, all of the elements of her claim. It is the function of the Commission to judge the credibility of the witnesses and resolve conflicts in medical evidence. *See, O'Dette v. Industrial Comm'n*, 79 Ill. 2d. 249, 253, 403 N.E.2d 221, 223 (1980). In deciding questions of fact, it is the function of the Commission to resolve conflicting medical evidence, judge the credibility of the witnesses and assign weight to the witnesses' testimony. *See, R & D Thiel*, 398 Ill. App.3d at 868; *See also, Hosteny v. Workers' Compensation Comm'n*, 397 Ill. App. 3d 665, 674 (2009).

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

The parties stipulated to the occurrence of an accident on February 24, 2010, the date of Petitioner's original lifting injury in case number 10WC 32452) however, Respondent disputes the occurrence of a second accident on August 3, 2010 (10WC 32453). The Arbitrator notes Petitioner's credible and unrebutted testimony of an exacerbation of her pain after driving over a bump in the flooring at work. This history of injury is in complete agreement with the detailed history of injury recorded that same day in the records of Respondent's own Advocate, where the treating doctor found a sharply increased pain level and ordered Petitioner off work.

In view of this evidence, the Arbitrator takes notice of the parties' stipulation to accident and timely notice on February 24, 2010 (10WC 32452), and further finds that a second accident occurred on August 3, 2010 (10WC 32453). The Arbitrator finds that Respondent received timely notice of that accident.

E. regarding timely notice of accident, the Arbitrator finds as follows:

The Arbitrator notes Petitioner's credible and unrebutted testimony of giving notice to her supervisor, Ms. Cybolski and concludes that timely notice was given to Respondent.

F. Is the Petitioner's present condition of ill-being is causally related to her injury? :

It is within the province of the Commission to determine the factual issues, to decide the weight to be given to the evidence and the reasonable inferences to be drawn there from; and to assess the credibility of witnesses. *See, Marathon Oil Co. v. Industrial Comm'n*, 203 Ill. App. 3d 809, 815-16 (1990). And it is the province of the Commission to decide questions of fact and causation; to judge the credibility of witnesses and to resolve conflicting medical evidence. *See, Steve Foley Cadillac v. Industrial Comm'n*, 283 Ill. App. 3d 607, 610 (1998).

It is established law that at hearing, it is the employee's burden to establish the elements of his claim by a preponderance of credible evidence. *See, Illinois Bell Tel. Co. v. Industrial Comm'n.*, 265 Ill. App. 3d 681; 638 N.E. 2d 307 (1st Dist. 1994). This includes the issue of whether Petitioner's current state of ill-being is causally related to the alleged work accident. *Id.* A claimant must prove causal connection by evidence from which inferences can be fairly and reasonably drawn. *See, Caterpillar Tractor Co. v. Industrial Comm'n.*, 83 Ill. 2d 213; 414 N.E. 2d 740 (1980). Also, causal connection can be inferred. Proof of an employee's state of good health prior to the time of injury and the change immediately following the injury is competent as tending to establish that the impaired condition was due to the injury. *See, Westinghouse Electric Co. v. Industrial Comm'n*, 64 Ill. 2d 244, 356 N.E.2d 28 (1976). Furthermore, a causal connection between work duties and a condition may be established by a chain of events including Petitioner's ability to perform the duties before the date of the accident and inability to perform the same duties following that date. *See, Darling v. Industrial Comm'n*, 176 Ill.App.3d 186, 193 (1986).

The records of Advocate consistently relate Petitioner's symptoms to her injury of February 24, 2010, after lifting several fifty (50) pound sacks of salt at work. They also record an exacerbation of her symptoms on August 3, 2010, after driving her forklift over a rough surface. Dr. Sweeney, one of Advocate's orthopedic surgeons, confirmed this history of injury and further found that Petitioner's MRI showed a significant disk herniation. Based on his recommendation, the respondent approved surgery to correct the herniated lumbar disk.

Dr. Ghanayem, Petitioner's second choice of treating surgeon, agreed with Dr. Sweeney's diagnosis, while opining that further conservative care might serve Petitioner's needs better than surgery. His records and those of Dr. Bajaj, the pain specialist he referred Petitioner to, reflect an identical history of an injury after lifting heavy sacks at work, with no history of prior back injury or medical treatment. Following a largely unsuccessful course of conservative care, she was given permanent restrictions well below the level of her previous job. No physician, including but not limited to Dr. Troy, Respondent's IME doctor, has declared her pain-free or released her to resume her pre-injury job duties.

Dr. Spencer, who saw Petitioner in 2013, found that the protruding material from the herniated lumbar disk had been partially re-absorbed in the three years since her injury; however, he explained that Petitioner still suffered from a severely degenerated L5-S1 disk, resulting in chronic back and leg pain. Dr. Spencer opined that her current symptoms were "completely related" to the original lifting injury in 2010.

Respondent's Section 12 examiner, Dr. Troy provides the only dissent to this causal framework, arguing that Petitioner's current complaints were due to her pre-existing, degenerative arthritis. He cited Petitioner's weight and her smoking as causal factors. Dr. Troy opined that the injury was a simple strain, which had caused only temporary impairment, and the petitioner has now returned to her baseline condition of chronic back pain and physical limitations, that predated the injury.

The Arbitrator finds the opinions of Drs. Sweeney and Bajaj to be more persuasive than those of Dr. Troy. Also, Petitioner's credible, unrebutted testimony established that prior to February 24, 2010, she had worked for five years in an industrial setting, performing heavy lifting, without restrictions. Her testimony was buttressed by evidence that the respondent had specifically recognized her for achieving production goals that were high by any standard; and for being the first female employee in company history to do so.

Causation in a workers' compensation case may be established by a chain of events showing prior good health, an accident and a subsequent injury. *Gano Electric Contracting v. Industrial Comm'n*, 260 Ill.App.3d 92, 96-97, 631 N.E.2d 724 (1994); *see also Darling v. Industrial Comm'n*, 176 Ill.App.3d 186, 193, 530 N.E.2d 1135 (1988). In this case, the evidence shows a history of above-average performance in a physically demanding job prior to the initial date of accident. Following that date, she was continuously placed off work or confined to restricted duty by her treating physicians, and no medical provider ever lifted those restrictions. The respondent offered no evidence of prior medical treatment or disability, and its examiner, Dr. Troy, cited no such evidence. Moreover, it is axiomatic that aggravation of a pre-existing condition is compensable under Illinois law. *Sisbro v. Industrial Comm'n*, 207 Ill.2d 193, 205 (2003).

The Arbitrator further notes that while Dr. Troy's claims Petitioner's complaints of radicular left leg pain did not begin with the injury but set in "sometime later"; these claims are not supported by the records of Advocate, which note back pain "radiating into legs" on the date of injury. The same records also note that Petitioner was physically active, exercising frequently and coaching basketball prior to her injury.

The Arbitrator finds that the petitioner's testimony as to her physical condition before and after the accident dates was credible and consistent with the treating medical records, as well as other evidence

supporting her history of physically challenging work prior to February 24, 2010 and inability to resume such work following the accident.

Therefore, the Arbitrator finds that the petitioner has met her burden of proving, by a preponderance of the evidence, a causal connection between her work accidents of February 24, 2010 and August 3, 2010 and her current condition of ill-being. After reviewing all the testimony and medical evidence, the Arbitrator finds the original lifting injury of February 24, 2010 to be the precipitating event responsible for Petitioner's current condition of ill-being, and awards benefits pursuant to that date of accident.

K. Is the Petitioner's entitled to prospective medical care?

Following her injury of February 24, 2010, the Petitioner remained on light duty and in treatment at Advocate, with significant ongoing pain. After a second incident on August 3, 2010 exacerbated her pain, she was taken off work. She was referred by the clinic to an orthopedic surgeon, Dr. Sweeney, who first recommended injections and then surgery. Respondent approved Dr. Sweeney's surgical recommendation; however, Petitioner sought a second opinion from Dr. Ghanayem, in an attempt to avoid surgery, if possible. She was then referred to Dr. Bajaj for pain management.

Following seventeen months of treatment, including medications, physical therapy and injections, Dr. Bajaj released Petitioner from his care with permanent restrictions, including a seventeen (17) pound lifting limit and restrictions on standing and sitting. However, his records clearly reflect that she continued to experience chronic pain and would require further medical care in the future. Dr. Bajaj simply noted that he had little more to offer her in the way of treatment, at that time.

Based on Dr. Bajaj's opinion, Petitioner made diligent attempts to find a new job within her restrictions, and did not actively seek further medical care for over a year. However, she testified that she continued to have low back and leg pain, which she tried to control with ibuprofen. On at least one occasion in 2012, her worsening pain caused her to seek emergency care at St. Joseph's Hospital. When a family friend recommended Dr. Spencer, Petitioner reasonably sought further consultation, to determine if the medical system did have something further to offer her. The Arbitrator further notes that Respondent's Section 12 examiner, Dr. Troy, agreed with Dr. Spencer's surgical recommendation, while denying that her need for surgery, could be traced to her industrial accident.

Having found a causal connection between the workplace accident and Petitioner's current condition of ill-being, the Arbitrator therefore adopts the opinions of Drs. Spencer, Sweeney and Troy, that further treatment in the form of surgery is reasonable and necessary. Such treatment is considered to have been "incurred" as set forth in *Plantation Mfg. Co. v. Industrial Comm'n*, 294 Ill. App. 3d 705,

691 N.E.2d 13 (1997). Respondent is ordered to authorize and pay for the lumbar fusion surgery recommended by Dr. Spencer, and for reasonable and necessary post-operative care.

L. What temporary benefits are in dispute?

The parties stipulated that the petitioner received TTD benefits from August 4, 2010 through July 5, 2011, when Dr. Bajaj issued permanent work restrictions. She then embarked on a search for alternate employment within her restrictions under the guidance of vocational rehabilitation specialists selected by Respondent. The parties stipulated that Petitioner received maintenance benefits from July 6, 2011 through June 27, 2013, with the exception of a brief period, October 30, 2012 through November 9, 2012. During this time, Petitioner found temporary work and resumed receiving TTD benefits as of June 28, 2013; following Dr. Spencer's recommendation for spinal fusion surgery.

Petitioner claims ongoing eligibility for TTD benefits through the date of trial. Respondent contends that Petitioner's eligibility for TTD benefits ended October 1, 2013, when its Section 12 examiner, Dr. Troy, opined that her condition was unrelated to her work injury. And is asserting an overpayment of approximately four weeks.

Having found causal connection, the Arbitrator notes that Dr. Bajaj imposed permanent, light-duty, work restrictions on July 5, 2011. These restrictions were accepted by Respondent's vocational consultants, as the basis for her search for alternate employment. The records of that search effort indicate a diligent but unsuccessful job search by Petitioner. Said records are supported by Petitioner's unrebutted testimony, including her acceptance of temporary-agency work in the fall of 2012. Finally, there is no evidence that Respondent, at any time, offered Petitioner alternate work within her physical restrictions.

Spinal fusion surgery has now been prescribed for Petitioner by Dr. David Spencer, which the Arbitrator has found to be reasonable and necessary. Respondent's examiner, Dr. Troy , has agreed that this surgical recommendation is necessary. On July 15, 2013, the respondent terminated its vocational rehabilitation services and ordered the Petitioner's file closed because of Dr. Spencer's surgical recommendation. The parties have stipulated that Petitioner was taken off maintenance benefits and placed back on TTD at that time.

Taken as a whole, the evidence establishes that the petitioner has not been released from medical care and has not reached maximum medical improvement, and Respondent is therefore liable for ongoing benefits. *See Westin Hotel v. Industrial Comm'n*, 372 Ill.App.3d 527, 865 N.E.2d 342 (2007).

The Arbitrator therefore awards TTD and maintenance benefits from August 4, 2010 to the date of trial, February 20, 2014, for a total of 183-5/7 weeks. Respondent is awarded credit for TTD and maintenance benefits already paid to date, and is held liable for continuing benefits through Petitioner's surgery and post-operative recovery period.

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
10WC32452
10WC32453
SIGNATURE PAGE

Signature of Arbitrator

April 8 2014
Date of Decision

STATE OF ILLINOIS)
) SS.
COUNTY OF MCCLEAN)

☒ 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

Christopher A. Crain,
Petitioner,
vs.
Wal-Mart Associates, Inc.,
Respondent,

NO: 11 WC 26867

15IWCC0016

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 3, 2014 is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $8,075.00. 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: JAN 12 2015

MB/mam
o:11/20/14
43

Mario Basurto

David L. Gore

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CRAIN, CHRISTOPHER
Employee/Petitioner

Case# **11WC026867**

15IWCC0016

WAL-MART ASSOCIATES INC
Employer/Respondent

On 1/3/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.09% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0564 WILLIAMS & SWEE LTD
STEVE WILLIAMS
2011 FOX CREEK RD
BLOOMINGTON, IL 61701

0560 WIEDNER & McAULIFFE LTD
RANDALL W SLADEK
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

15IWCC0016

STATE OF ILLINOIS)
)SS.
COUNTY OF MCLEAN)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

CHRISTOPHER A. CRAIN,
Employee/Petitioner

v.

WAL-MART ASSOCIATES, INC.,
Employer/Respondent

Case # 11 WC 26867

Consolidated cases: NONE.

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Joann M. Fratianni**, Arbitrator of the Commission, in the city of **Bloomington**, on **October 21, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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: _____

15IWCC0016

FINDINGS

On **November 20, 2010**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$17,199.00**; the average weekly wage was **$330.75**.

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

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

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

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

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

ORDER

Respondent shall further pay Petitioner permanent partial disability benefits of **$319.00**/week for **25** weeks, because the injuries sustained caused the **5%** loss to his **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.

JOANN M. FRATIANNI
Signature of Arbitrator

December 27, 2013
Date

JAN 3 - 2014

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

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

Petitioner testified that on November 20, 2000, he worked for Respondent. While unloading a truck on that date, 4-5 boxes fell and struck him in the neck and right shoulder. Petitioner testified that following that incident, he was in immediate pain in his neck and right shoulder.

Later that day, he sought medical treatment in the emergency room of OSF St. Joseph Medical Center. A history of injury was recorded by the hospital consistent with Petitioner's testimony. Petitioner was examined and discharged with a prescription for pain medication. On November 24, 2010, Dr. Madugula, of OSF St. Joseph Healthcare, recorded a history of headaches for the past few days after a box fell on his head at work. He further reported right arm pain after performing exercises at home. Dr. Madugula prescribed pain medication.

Petitioner then returned to the emergency room on December 5, 2010 with head pain, which was described as having started 6-12 hours earlier. The headache was described as being dull and was associated with "nothing." Examination revealed diffuse tenderness about the head and neck with no raised or focal area of trauma. Petitioner was discharged with medication. On December 7, 2010, Petitioner saw Dr. Madugula for neck pain and headaches. Petitioner described these symptoms as constant pain sometimes aggravated by movement, and sharp pain in the front and back of his head. X-rays of the cervical spine were performed and were described as being negative. Physical therapy was prescribed.

On January 10, 2011, Petitioner followed up with Dr. Madugula for headaches and neck pain. Physical therapy was prescribed which after one session reported neck pain relief. Dr. Madugula prescribed a return visit in four weeks.

On January 24, 2011, Petitioner received a job offer from Respondent. Petitioner accepted this offer in writing and signed the document. This offer provided him work within the restrictions of Dr. Madugula of no overhead lifting, no above shoulder work, no twisting, no ladder work, no stooping, no bending, no pushing or pulling greater than 10 pounds, and no lifting or carrying greater than 10 pounds. Petitioner was offered positions in the fitting room and as a store greeter.

On February 15, 2011, Petitioner underwent MRI examinations of the cervical and thoracic spine. These were prescribed by Dr. Madugula. Both MRI examinations were described as being unremarkable. Petitioner also saw Dr. Parikh at OSF Healthcare on March 10, 2011. Dr. Parikh prescribed an EMG/NCV study. That study was performed on March 21, 2011 by Dr. Parikh, who described it as being negative.

Petitioner last worked for Respondent on April 12, 2011. At that time he was terminated for excessive absence and/or being tardy.

On April 27, 2011, Petitioner presented to Dr. Parikh with posterior cervical pain. Petitioner was prescribed a cervical facet medial branch block by Dr. Parikh which he underwent that same day. Dr. Parikh diagnosed cervical osteophyte and neck pain. A second injection was prescribed and performed by Dr. Parikh on May 11, 2011 with a third on June 29, 2011.

When seen by Dr. Parikh, Petitioner also complained his neck felt as though someone was squeezing it. He reported his right shoulder pain had resolved to the point where he could now mow his lawn. Petitioner continued treatment with Dr. Parikh through December 8, 2011. During this time he continued to be unemployed and under certain medical restrictions.

Dr. An examined Petitioner on January 10, 2012. This examination was at the request of Respondent. Dr. An noted chronic cervical strain and possibly facet related neck pain. Dr. An was unable to find any evidence of radiculopathy, herniated disc or spinal stenosis. Dr. An diagnosed minimal degenerative changes at C4-C5 as noted by the MRI, which was pre-existing in nature. Dr. An felt that Petitioner was at medium physical duty level with no lifting more than 25 pounds and no frequent bending and twisting. Dr. An felt that Petitioner would reach maximum medical improvement in one month.

On February 17, 2012, Petitioner was examined by Dr. Jhee through a referral by Dr. Parikh. Petitioner reported neck, upper back and shoulder blade pain without radiation to the upper extremities. He reported he was looking for a job and had been denied Social Security Disability benefits. The final records of Dr. Jhee reflect that Petitioner's neck pain was increasing. The Dr. Jhee recorded complaints that Petitioner's neck pain was increasing. The doctor prescribed medical restrictions of 10 pounds lifting frequently, 20 pounds occasionally and no overhead work.

Dr. Jhee testified by evidence deposition on July 15, 2013. He testified that Petitioner complained of neck pain with cold weather but did not have an opinion on what attributed that condition. Dr. Jhee testified that he diagnosed cervical disc disease with cervical radicular pain, myofascial pain syndrome and status post-cervical strain. Dr. Jhee felt there was some relationship between his findings to the neck and the injury at work. Based on pain complaints, Dr. Jhee prescribed sedentary work. Dr. Jhee did admit that he removed all medical restrictions at Petitioner's request when he was looking for employment and the doctor had been advised of the job search efforts. Dr. Jhee acknowledged the medical restrictions were based on subjective symptoms. When asked if Petitioner's symptoms were believable, Dr. Jhee replied "to a certain extent." Dr. Jhee further testified the diagnostic testing did not match with the reported symptoms.

Petitioner testified that he is unable to work, that his pain is increasing, that he must sleep on the couch and he uses an electric cart while grocery shopping.

Based upon the above, the Arbitrator finds the cervical strain as diagnosed by Dr. An is causally related to this accidental injury. At best Petitioner suffered a cervical spine strain with all diagnostic testing described as being normal.

Based further upon the above the Arbitrator finds the diagnosed cervical strain is now permanent in nature.

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

Petitioner introduced into evidence the following medical charges for treatment that were incurred after this accidental injury:

OSF Healthcare	$505.00
OSF St. Joseph Medical Center	$1,503.60
Heartland Emergency Specialists	$774.00
Millenium Pain Center	$340.00
Pharmacy Prescriptions	$17.20

These charges total $3,294.60.

Respondent does not challenge the medical services provided prior to January 10, 2012, the date of the examination by Dr. An.

The above listed charges are hereby denied a having been incurred subsequent to date. All charges incurred by Petitioner before January 10, 2012 have been paid by Respondent.

Accordingly all medical charges incurred prior to January 10, 2012 are awarded and found to be causally related to this accidental injury.

In addition, Respondent's group insurance carrier paid other charges, for which Respondent is entitled to receive a credit as against this award. It will also be the responsibility of the parties to determine the amounts credited under these circumstances and Respondent is to hold Petitioner safe and harmless from all attempts at reimbursement by said health provider pursuant to the provisions of Section 8(j) of the Act.

K. What temporary benefits are in dispute?

See findings of this Arbitrator in "F" and "L" above.

Petitioner claims to be entitled to receive temporary total disability benefits from April 12, 2011 through August 30, 2012. As indicated above, Petitioner was terminated from employment with Respondent on April 12, 2011. Petitioner was given a decision day on April 9, 2011 in accordance with attendance policy. He was given a paid day off to compose and return a written action plan and present it to management. He failed to do so. When given a second opportunity, Petitioner refused and was terminated. Petitioner claimed to be unable to drive, but Dr. Madugula did not restrict him from driving.

Prior to that date, Petitioner worked modified jobs that met the medical restrictions of Dr. Madugula. In addition, medical evidence before this Arbitrator reflects that Petitioner was under medical treatment for gallbladder surgery and gastroesopheajeal reflux disease during the same period of time he was claiming temporary total disability or this cervical strain injury.

Based upon the above, the Arbitrator finds that as a result of this accidental injury, Petitioner did not become temporarily and totally disabled from work after April 12, 2011 and all such claims for benefits made by him after that date are hereby denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Alejandro Ceja,

Petitioner,

vs. NO: 13 WC 07564

Ed Miniat, Inc.,

15IWCC0017

Respondent,

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 27, 2014 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: JAN 12 2015

MB/mam
o:11/13/14
43

Mario Basurto

David L. Gore

Stephen Mathis

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

CEJA, ALEJANDRO
Employee/Petitioner

Case# **13WC007564**

15IWCC0017

ED MINIAT INC
Employer/Respondent

On 5/27/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% 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:

1836 RAYMOND M SIMARD PC
221 N LASALLE ST
SUITE 1410
CHICAGO, IL 60601

0075 POWER & CRONIN LTD
JEFFREY B REDICK
900 COMMERCE DR SUITE 300
OAKBROOK, IL 60523

15IWCC0017

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)

Alejandro Ceja
Employee/Petitioner

v.

Ed Miniat, Inc.
Employer/Respondent

Case # **13** WC **7564**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Deborah L. Simpson**, Arbitrator of the Commission, in the city of **Chicago**, on **October 8, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **September 27, 2012**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$34,235.24**; the average weekly wage was **$658.37**.

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

ORDER

The Petitioner has proven by a preponderance of the evidence that he sustained accidental injuries that arose out of and in the course of his employment, that his current condition of ill-being is causally related to the injury and that he provided timely notice of the accident within the time limits stated in the Act.

The claim for temporary partial disability compensation from April 1, 2013 through October 8, 2013 is denied.

The Respondent shall authorize and pay for the treatment recommended by Dr. Nigro which includes an updated EMG, a left lateral epicondylar release, a left cubital tunnel release pursuant to the EMG results and conservative care to the right elbow.

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

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

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

Deborah L. Simpson
Signature of Arbitrator

May 23, 2014
Date

ICArbDec19(b)

MAY 27 2014

15IWCC0017

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Alejandro Ceja,	)	
	)	
Petitioner,	)	
	)	
vs.	)	**No. 13 WC 7564**
	)	
Ed Miniat,	)	
	)	
Respondent.	)	
	)	

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

The parties agree that on September 27, 2012, the Petitioner and the Respondent were operating under the Illinois Worker's Compensation or Occupational Diseases Act and that their relationship was one of employee and employer. They agree that in the year preceding the injuries, the Petitioner earned $34,235.24, and that his average weekly wage was $658.37.

At issue in this hearing is as follows: (1) Did the Petitioner sustain accidental injuries that arose out of and in the course of her employment; (2) Did the Petitioner give the Respondent notice of the accident within the time limits stated in the Act; (3) Is the Petitioner's current condition of ill-being causally connected to this injury or exposure; and (4) Is the Petitioner entitled to TPD from April 1, 2013 through October 8, 2013, a total of 27 2/7 weeks.

This matter proceeded to trial pursuant to a Petitioner for hearing under Section 8(a) of the Act with Petitioner seeking authorization for medical treatment on his elbows as recommended by Dr. Phillip T. Nigro.

STATEMENT OF FACTS

The Petitioner was employed by the Respondent as a Processing Laborer, sometimes referred to as Policlip Machine Operator. Petitioner began working for the Respondent in a permanent position January 31, 2011, but had worked there previously as a temporary employee. As a temporary employee the Petitioner had a different job than the one he currently holds. Petitioner started in the position of a Policlip Operator one month after he was hired as a permanent employee. Petitioner's hours were 3 PM to 12:30 AM with a fifteen minute break and a thirty minute lunch. He was paid for nine hours per day and worked five days per week. According to the Petitioner between March 1, 2011 and October 1, 2012, he worked almost every Saturday. Saturday was overtime. Additionally, after eight hours each day they received

overtime pay for the additional time that they worked. There were days when they worked past 12:30 AM because they had to stay and finish the job.

Evidence showed that the Petitioner's job functions included the preparation of meat product for entrance into the cooking machine. The Petitioner was required to push and shape cased meats so that the product could enter the machine. The Petitioner described using his hands and arms to flatten the meat. According to Megan Robinson, Human Resources Manager for Ed Miniat, in performing the position of Processing Laborer, in which the Petitioner was employed at all the times that related to this case, individuals push or flatten meat using extended wrists and extended elbows (Trial Transcript p. 44-45).

At the hearing, the Petitioner demonstrated his work activities which were consistent with the description given by the Human Resources Manager. He also described his work activities. Petitioner testified that the policlip job required him to press packages of meat until the meat was two inches high. He would then grab the packages at the tips and set them on racks. (p. 59). Petitioner pressed the meat with the palms of his hands. The longer tubes of meat were three feet long and five inches in diameter. The shorter tubes were fifteen inches long and seven inches in diameter. (p. 62-63). He would process about 140 long tubes per hour or 250 short tubes per hour. (p. 65). Petitioner testified that a photo (Nigro Dep #8 and PX9) fairly represented the position of his arms and hands as he performed the policlip job. (p. 64-65). He used his thumb and fingers in a pinching manuver to pick up the finished product. (p. 66).

Early in the year 2012 Petitioner noticed that his hands cramped, became cold and fell asleep. He eventually noticed these symptoms at work but more so at night. He first sought care at the Union Medical Center on July 2, 2012 where he reported that his hand condition was not work related. (p. 67). He was prescribed wrist splints. An EMG of his arms on August 2, 2012 was negative. He attended physical therapy at the Union Medical Center. On September 12, 2012, he gave an eight month history of bilateral arm pain at the Union Medical Center. He again denied that his symptoms were work related but Dr. Santos-Leal noted that repetitive tasks worsened the pain. (PX1). He saw a neurologist, Dr. Park, the same day who found bilateral tennis elbow on testing. (PX1). He ordered physical therapy, Voltaren gel and counterforce elbow braces. (PX1). On September 27, 2012 Petitioner returned to Dr. Santos-Leal and reported that he believed that his condition was work related. (p. 68).

Petitioner reported to his supervisor Mr. Bocanegra on September 27, 2012 that the condition of his elbows and hands was related to the work he performed. (p. 69). Petitioner testified that he related his arm and hand condition to his work activity on that date because he would have pain whenever he would work. (p. 69).

Mr. Bocanegra gave him an accident report to complete on September 27, 2012. (p. 69). Petitioner reported the day of accident as June 2012 when he was exerting himself with his arms to press the tubes of meat. (p. 72). He did not report these symptoms right away because he thought the symptoms were not serious and would pass quickly. (p. 73)

Megan Robinson referred him to the Ingalls Occupational Clinic on October 1, 2012. He complained of bilateral arm and hand pain. (PX2). The exam revealed bilateral tenderness over the lateral epicondyle and pain in the lateral condyle when the wrist was extended against force.

(PX2). On October 8, 2012 Dr. Akbar noted that the bilateral elbow pain was made worse by repetitive pushing down movement. (PX2). He diagnosed bilateral epicondylitis and placed Petitioner on light duty. On October 23, 2012, Dr. Akbar referred Petitioner to Dr. Philip Nigro, an orthopedic surgeon. (PX2)(p. 77).

Petitioner saw Dr. Nigro on November 1, 2012 where he filled out a questionnaire. Petitioner attributed his complaints to pressing down 8 or 9 hours. (PX3)(p. 77). Dr. Nigro injected his left elbow on November 29, 2012 and January 24, 2012. Dr. Nigro prescribed an updated EMG and surgery to the left elbow on March 14, 2013 and at subsequent office visits. (p. 79). He wishes to have the treatment prescribed by Dr. Nigro. (p. 84).

Petitioner has not had the prescribed EMG and surgery. He complained of pain in his elbows and numbness in his hands for which he takes medication. (p. 80). His light duty restrictions were modified on April 1, 2013 by Dr. Nigro to include no lifting over one pound with the left hand and no repetitive work for more than 30 minutes. (p. 80).

On April 1, 2013, Respondent limited his hours to 40 per week even though his department was working for 42.5 hours, more or less, per week. (p. 83). Additional restrictions regarding his use of his left arm and the weight he could lift, as well as how he lifted and or passed the tubes of meat were added by various treators. He testified that the Respondent has honored these restrictions although occassionally he has done some of the actions he was prohibited from doing. His department normally works every Saturday. (p. 82). He got a raise in November 2012 of $0.33 per hour but could not remember his exact hourly rate from April 1, 2013 to the date of arbitration. (p. 84).

On cross-examination, Petitioner testified that he worked overtime because they could not leave unfinished product on the table. (p. 87). He always told his treating physicians what he noticed about himself and answered their questions as truthfully and completely as possible. (p. 91). Petitioner did not deny giving the histories recorded at the Union Medical Center on July 2, 1012 and August 2, 2012. (p. 92). He thought his symptoms were related to his blood. (p. 93). The Union Clinic also treated him for vitiligo which is a discoloration that he has on his hands and body. (p. 95) Per the testimony of Dr. Neal, it is a condition related to the pigmentation of the skin. (RX 1,pp. 42-43)

The Petitioner testified that he does want to continue with treatment from Dr. Nigro and to have the treatment prescribed by him.

The first witness that was called to testify by the Petitioner was Megan Robinson, the Human Resources Manager for Respondent. Ms. Robinson testified that her responsibilities include administering the workers' compensation program. (p. 15). She is aware that Petitioner operated a policlip machine the first nine months of 2012. (p. 15)

Ms. Robinson produced pursuant to subpoena an injury report form (PX7) completed by Luis Bocanegra, Petitioner's supervisor, on September 27, 2012. (p. 16). According to the Incident Report, Petitioner complained of a three month history of bilateral elbow pain when working on the policlip machine which requires him to put pressure on the elbows. (p. 18). Mr. Bocanegra's assessment as to how the accident happened was "Ergonomic factors, repetitive

motions", (PX7)(p. 18). Mr. Bocanegra recommended rotating employees for this job and finding equipment to "avoid this happening again". (p. 19). When asked why this accident occurred Mr. Bocanegra wrote "When we run this type of product slack fill, the person on the policlip have to disperse the meat evenly on the whole tube and he have to put pressure on the tube in order to disperse using two hands". (PX7)(p. 20). Mr. Bocanegra added that this job is sometimes performed for an entire shift. (p. 20).

Ms. Robinson testified that she did not recall the normal starting and quitting times for the second shift on which Petitioner worked. (p. 21). She agreed that Petitioner would at times be required to work later than his normal quitting time; that there is Saturday overtime where employees receive attendance warnings when they failed to appear. Petitioner currently earns $13.21 per hour. (p. 22). She did not know when he got a raise from $12.91 per hour. (p. 23). Ms. Robinson also did not know if the normal shift hours were reduced from 9 to 8.5 in late 2012 (p. 24). She identified a punch detail report showing the number of hours worked on each day. (p. 24)

Ms. Robinson could not recall if she referred Petitioner to Ingalls Occupational Health on October 1, 2012, after the Petitioner reported his injury, although she normally refers injured employees to that clinic. (p. 28).

On cross-examination by Respondent, Ms. Robinson testified that injured employees are to report all incidents immediately and managmeent is to complete a report within 24 hours. (p. 34). It is undisputed that Petitioner first gave notice that he injured himself on September 27, 2012. (p. 34-35). Ms. Robinson identified the report dated September 27, 2012 as relating to the injury described as occurring on October 1, 2012. (RX3). P. 37

The information placed on an incident report is the supervisor's assessment of the situation. (p. 39). To her knowledge, the process laborer position is accurately described on RX4.(p. 42). Based upon her experience and information in dealing with process laborer positions, the job requires the pushing and flattening of meat using extended wrists and elbows. (p. 44). The flattening and reconfiguration of the meat allows it to fit into the machine or the cooking apparatus. (p. 45). She identified RX5 as a punch detail list showing the hours worked by Petitioner through October 3, 2013.

The deposition of Dr. Philip T. Nigro (PX5) was taken on July 11, 2013. Dr. Nigro testified that he was licensed to practice medicine in the State of Illinois in June of 2012. He is not Board Certified, however he is Board eligible, he has passed part one of the boards and is due to sit for part 2 in a year. (p. 4-5)

Dr. Nigro testified that he first examined Petitioner on November 1, 2012 on a referral from the Ingalls Occupational Clinic. Petitioner gave a history of bilateral pain in the lateral side of the elbow as the result of pushing and pulling meat for eight or nine hours per day. (p. 7-8). Dr. Nigro treated only the left elbow as the workers' compensation carrier did not authorize treatment to the right elbow. (p. 8). Dr. Nigro diagnosed lateral epicondylitis of the left elbow. (p. 10). The cubital tunnel test was slightly positive. (p. 9). Dr. Nigro treated the left elbow with injections and light duty. On January 24, 2013 Petitioner complained of increasing right elbow pain from favoring the left elbow. (p. 12).

Dr. Nigro examined Petitioner on March 7, 2013 and noted a positive cubital tunnel test and elbow flexion test on the left side. He made the additional diagnosis of ulnar neuritis. (p. 13). On March 14, 2013, Dr. Nigro prescribed an updated EMG and, pending the EMG results, a left tennis elbow release and a cubital tunnel release. (p. 14).

On March 28, 2013, Dr. Nigro examined the right elbow and changed his diagnosis to bilateral lateral epicondylitis and bilateral ulnar neuritis. (p. 15). Dr. Nigro saw Petitioner for the last time on June 13, 2013 (p. 17). His current treatment recommendation is a repeat EMG, a left tennis elbow (lateral epicondylitis) release and for the right elbow, counterforce strapping, palms up lifting techinique and oral inflammatories. (p. 18).

Dr. Nigro viewed the photo (Dep Ex. 2 and PX9) of a worker pressing down on a three foot tube of meat with extended wrists and near fully extended elbows in the same manner described to him by Petitioner. (p. 19). Dr. Nigro opined that there was a causal connection between the pressing down activity and the bilateral lateral epicondylitis and ulnar neuritis. (p. 20). Dr. Nigro explained that the tennis elbow (lateral epicondylitis) was caused by the overuse of the elbow. (p.20). The same overuse resulted in ligament swelling at the elbow which compressed the ulnar nerve in the cubital tunnel resulting in ulnar neuritis or cubital tunnel syndrome. (p. 20). Dr. Nigro found Petitioner's work activity to be a competent cause for the bilateral elbow conditions. (p. 21 and 38).

The deposition of Dr. M. Bryan Neal (RX1) was taken on August 20, 2013. Dr. Neal, testified that he is Board Certified orthopedic surgeon, and that he examined the Petitioner at the request of someone named Shirley Lacock on February 26, 2013. Dr. Neal examined medical records commencing on October 1, 2012 from the Ingalls Occupational Clinic. (p. 10). He also reviewed the records of Dr. Nigro through January 24, 2013. Dr. Neal opined that there was no causal connection between Petitioner's symptoms and any incident on October 1, 2012 because there was no incident that day and Petitioner had complaints before that date. (p. 27). There was also no causal connection to any September activity because he had complaints prior to September. (p. 28). Dr. Neal did not believe that the work activity would cause the simultaneous onset of both conditions. (p. 28). His understanding of the work is that it involved mostly passive wrist extension which does not strain the lateral tendon in the elbow. (p. 29). As to the ulnar neuritis, he testified that the forces creating intracubital tunnel pressure are greater with elbow flexion. Dr. Neal did not believe that Petitioner's work position would cause the cubital tunnel symptoms. (p. 29). Dr. Neal made conservative treatment recommendations for the elbows. (p. 30).

Dr. Neal authored a second report on July 24, 2013 after reviewing additional medical records from the Union Medical Center and subsequent records from Dr. Nigro. Based upon his review of the additional medical records, Dr. Neal diagnosed Petitioner as having bilateral lateral epicondylitis and bilateral ulnar neuritis. (p. 38). Dr. Neal recommended light duty and a repeat EMG. (p. 39).

Dr. Neal opined that neither bilateral conditions could be caused by any work incident as none occurred. (p. 40). He also opined that the medical records and the history that he obtained

did not support a finding that Petitioner's occupational injuries caused his condition. Dr. Neal opined that the bilateral elbow conditions were idiopathic and that Petitioner was predisposed to these conditions by his middle age (43 years old) and obesity because he has a body mass index of 30. (p. 40-41). Dr. Neal opined that the work activity did not change Petitioner's pathogenic process but simply served as the "mechanism of expression" for his symptoms with no change in the underlying condition. (p. 42).

On cross-examination, Dr. Neal acknowledged that he was not provided a written job description and he has not viewed any photographs or films of anyone performing Petitioner's job. Nevertheless, Dr. Neal believed that he had an understanding of the work. (p. 49) Dr. Neal agreed that the onset of lateral epicondylitis and cubital tunnel syndrome can be insidious or intermittent. (p. 49). In the course of his practice he has treated patients with these conditions whose symptoms began intermittently and worsened progressively to the point where the symptoms are constant. (p. 51).

Dr. Neal acknowledged that obesity and middle age are risk factors for ulnar neuritis but these predisposing risk factors did not make it more likely that Petitioner would develop these conditions due to work activity. (p. 56).

At the conclusion of the testimony, the Arbitrator allowed Petitioner to amend the Application and the Request for Hearing (Arb Ex. 2) to show the alleged date of accident to September 27, 2012, rather than the type written date of October 1, 2012, which was on the filed petition. (Transcript p. 98-99) The petition alleges with respect to the question of how the accident occurred that it is "cumulative trauma."

CONCLUSIONS OF LAW

The burden is upon the party seeking an award to prove by a preponderance of the credible evidence the elements of his claim. *Peoria County Nursing Home v. Industrial Comm'n*, 115 Ill.2d 524, 505 N.E.2d 1026 (1987).

An injury arises out of one's employment if it has its' origin in a risk that is connected to or incidental to the employment so that there is a causal connection between the employment and the accidental injury. *Technical Tape Corp. vs IndustrialCommission,* 58 Ill. 2d 226, 317 N.E.2d 515 (1974) "Arising out of" is primarily concerned with the causal connection to the employment. The majority of cases look for facts that establish or demonstrate an increased risk to which the employee is subjected to by the situation as compared to the risk that the general public is exposed to.

Employment need only remain a cause, not the sole cause or even the principal cause, of a claimant's condition. *Rotberg v. Industrial Comm'n,* 361 Ill.App.3d 673, 682, 297 Ill.Dec. 568, 838 N.E.2d 55 (2005).

Because repetitive-trauma injuries are progressive, the employee's medical treatment, as well as the severity of the injury and particularly how it affects the employee's performance, are

relevant in determining objectively when a reasonable person would have plainly recognized the injury and its relation to work. *Oscar Mayer & Co. v. Industrial Commission,* 176 App.3rd 607, 610, 531 N.E. 2d 174.

An employee who suffers a repetitive trauma injury must meet the same standard of proof under the Act as an employee who suffers a sudden injury. See *AC & S v. Industrial Comm'n*, 304 Ill.App.3d 875, 879, 710 N.E.2d 837 (1st Dist. 1999)

An employee suffering from a repetitive trauma injury must still point to a date within the limitations period on which both the injury and its causal link to the employee's work became plainly apparent to a reasonable person. *Williams v. Industrial Comm'n*, 244 Ill.App.3d 204, 209, 614 N.E.2d 177 (1st Dist. 1993)

When the injury manifested itself is the date on which both the fact of the injury and the casual relationship of the injury to the claimant's employment would have become plainly apparent to a reasonable person. See *Peoria County Belwood Nursing Home v. Industrial Comm'n,* 115 Ill.2d 524 505 N.E.2d 1026 (1987). In *Peoria County*, the Illinois Supreme Court held that determining the manifestation date is a question of fact and that the onset of pain and the inability to perform one's job are among the facts which may be introduced to establish the date of injury. The Illinois Supreme Court in *Peoria County* determined that the manifestation date/date of accident in that case was the date that petitioner's pain, numbness, and tingling in her hands and fingers was so severe that she sought medical treatment.

The manifestation date is not the date on which the injury and its causal link to work became plainly apparent to a reasonable physician, but the date on which it became plainly apparent to a reasonable employee. *Durand*, 224 Ill.2d at 72. A formal diagnosis, of course, is not required. Id. In *General Electric Company v. Industrial Comm'n*, 190 Ill.App.3d 847, 857, 546 N.E.2d 987 (4th Dist. 1989), the appellate court held that the employee's injury and its connection to her employment would have been plainly apparent to a reasonable person on the date she noticed a "sharp pain" in her shoulder while working, not on the subsequent date when a physician opined that the employee's condition and her work were causally related.

Courts considering various factors have typically set the manifestation date on either the date on which the employee seeks medical treatment for the condition or the date on which the employee can no longer perform work activities. *Durand v. Industrial Comm'n*, 224 Ill.2d 53, 72, 862 N.E.2d 918 (2006).

Did Petitioner sustain accidental injuries that arose out of and in the course and scope of his employment with Respondent?

The Petitioner testified credibly that he worked five nine-hour days per week on the policlip machine from late February 2011 until September 27, 2012. This job required him to press forcefully on tubes of meat to evenly disperse meat inside the tube in preparation for cooking. Petitioner accomplished this task by pressing the meat with the palms of his hands with wrists extended and with his elbows not quite fully extended. Petitioner demonstrated this task at arbitration and offered into evidence a photograph of a co-worker performing the task. The Arbitrator noted no appreciable difference between the Petitioner's description and the activity

portrayed in the photograph. Dr. Nigro also viewed the photograph that was identified by the Petitioner as accurately depicting his job with respect to pressing on the meat.

The incident report completed September 27, 2012 (PX7) by Petitioner's supervisor, Bocanegra, corroborates Petitioner's description of his work duties. Bocanegra's assessment as to the cause of the accident was the constant and forceful pushing down movements by Petitioner. Bocanegra suggested rotating employees for that task or perhaps acquiring a piece of machinery to do that task.

Petitioner testified that he began to experience symptoms in his elbows and hands early in the year 2012. He would notice pain and numbness at work but more so at night. These symptoms progressively worsened and he first sought care at the Union Medical Center in July 2012. Petitioner initially denied a work related injury because he believed the problem was due to his blood and he suffered the pain at night at first, not when he was working.

Petitioner testified that on September 27, 2012 he reported his bilateral elbow condition as a work related accident because he made the association between the work activity and his condition of ill-being on that date. Petitioner noted that his elbows would hurt when he went worked. (p. 69).

In a repetitive trauma claim, the date of accident is the date on which both the fact of the injury and the causal relationship of the injury to the claimant's employment would have become plainly apparent to a reasonable person. *Peoria County Nursing Home v. Industrial Commission* 115 Ill. 2d 524, 531 (1987).

The Arbitrator finds that Petitioner became reasonably aware of a causal relationship between his work activity and his bilateral elbow condition on September 27, 2012 when he submitted an accident report to Bocanegra.

The Arbitrator recognizes that Petitioner denied that his bilateral elbow condition was work related on July 2, 2012 and at subsequent visits. An injured worker is not expected to be aware that his condition of ill-being is work related even after initial medical care. The date of accident is when the injured worker is put on reasonable notice that a causal relationship exists. *Three "D" Discount Stores v. Industrial Commission* 198 Ill App 3d 43, 47 (1989). An injured employee who continues to work on a regular basis despite his own progressive ill-being should not be punished merely for trying to perform his duties without complaint. *Durand v. Industrial Commission* 224 Ill 2d 53 (2006) citing *Three "D"* supra.

The Arbitrator finds that Petitioner sustained accidental injuries to his elbows arising out of and in the course of his employment by Respondent on September 27, 2012.

Did the Petitioner give the Respondent notice of the accident within the time limits stated in the Act?

The Petitioner reported the accident to his supervisor, Mr. Bocanegra, on September 27, 2012. The Petitioner completed an accident report (PX6) on that date and Mr. Bocanegra completed an incident report (PX7) the same day.

The Arbitrator finds that Petitioner gave Respondent timely notice of the accident.

Is Petitioner's present condition of ill-being is causally related to the injury?

Dr. Philip Nigro and Dr. M. Bryan Neal agree that Petitioner has bilateral lateral epicondylitis (tennis elbow) and bilateral ulnar neuritis (cubital tunnel syndrome). The doctors disagree as to the causal relationship of these conditions to the work activities.

Dr. Nigro, an orthopedic surgeon, treated Petitioner on a direct referral from the Ingalls Occupational Clinic where the employer sent Petitioner for treatment. Dr. Nigro obtained a job description from Petitioner. He advised Dr. Nigro that he pushed down on meat tubes with extended wrists and flexed elbows for eight or nine hours per day. Dr. Nigro also viewed the photograph (PX9 and Nigro Dep. Ex. 2) showing a co-worker performing that task. Dr. Nigro opined that there was a causal connection between the job activity and the bilateral conditions of ill-being in the elbows due to the overuse of the elbows. (p. 20 dep). Dr. Nigro opined that the overuse of the elbows at work was a competent cause for Petitioner's conditions of ill-being. (p. 38 dep).

Dr. Neal did not view any photographs, video or written job description for the policlip machine position. Dr. Neal opined that there was no causal relationship between the work activity and the bilateral elbow conditions of Petitioner. Dr. Neal believed that the work involved mostly passive wrist extension which does not cause lateral epicondylitis and that the work did not involve elbow flexion which can cause ulnar neuritis. (p. 29 Dep).

Dr. Neal opined that the cause of the bilateral elbow conditions was idiopathic. He opined that Petitioner had two risk factors: age (43) and obesity (BMI of 30) (p. 54 dep). These risk factors however did not predispose Petitioner to develop his bilateral elbow conditions from his work activity. (p. 55 dep).

The Arbitrator finds the testimony and opinions of Dr. Nigro to be more persuasive than those of Dr. Neal. The Arbitrator is aware of the fact that Dr. Nigro is not yet Board Certified, and Dr. Neal is, however Dr. Nigro has only been licensed to practice since 2012, is board eligible, having completed part 1 of the boards and due to sit for part 2 next year. Although the testimony of Dr. Nigro is lacking in some detail the responsibilities of the Petitioner with respect to his job he has better knowledge of the job duties of Petitioner than Dr. Neal does and his opinions on causal connection are more consistent with the evidence showing the frequent forceful use of the elbows in a flexed position with the wrists actively extended so that Petitioner could push down forcefully on the meat with the palms of his hands.

The Arbitrator finds that a causal connection exists between the accident of September 27, 2012 and the bilateral lateral epicondylitis and ulnar neuritis of Petitioner.

Is the Petitioner entitled to TPD from April 1, 2013 through October 8, 2013, a total of 27 2/7 weeks?

Petitioner claimed temporary partial disability benefits beginning on April 1, 2013 when Respondent limited his light duty hours to 40 hours per week. The employee bears the burden of proving by a preponderance of the evidence all of the elements of his claim. *R & D Thiel v. Workers' Compensation Comm'n*, 398 Ill. App. 3d 858, 867 (2010). An employer's liability for benefits cannot be based on guess, speculation or conjecture. *Illinois Bell Telephone* v. *Industrial Commission*, 265 Ill.App.3d 681, 638 N.E.2d 207 (1994).

The Arbitrator finds that Petitioner failed to provide a sufficient factual basis for the calculation of such an award. Petitioner did not know his hourly rate of pay for the period beginning April 1, 2013. (p. 85). He testified that his former shift worked 42.5 hours "give or take" during the period in question. The hours Petitioner worked often exceeded 40 hours per week according to the "punch detail list". (RX5). Finally, Petitioner did not know exactly how often his shift worked the mandatory Saturday overtime or provide any documentation that his shift worked any overtime during the time period he was on restricted duty and the Respondent honored the light duty limitations.

The claims for temporary partial disability benefits for the period of April 1, 2013 through October 8, 2013 are denied.

Is Petitioner entitled to prospective medical care?

Although the parties did not include prospective medical care as an issue on Arbitrator's Exhibit 1, the "stip sheet" otherwise known as IWCC Request for Hearing, this hearing was pursuant to a motion for hearing on Section 8(a) of the Act seeking authorization of medical treatment. The depositions that were taken of the treating doctor and the Section 12 examining doctor also included opinions as to reasonable and necessary medical treatment for the Petitioner's current medical condition with respect to his elbows and wrists as well as opinions regarding causal connection.

The Petitioner has proven by a preponderance of the evidence that he sustained accidental injuries that arose out of and in the course of his employment, that his current condition of ill-being is causally related to the injury and that he provided timely notice of the accident within the time limits stated in the Act.

Dr. Nigro has prescribed an EMG of the left arm, a lateral epicondylitis release and a possible cubital tunnel release pending the EMG results. (p. 14). Although Dr. Nigro has never been authorized to treat the right arm, Dr. Nigro recommended counterforce strapping, palms up lifting technique and oral anti-inflammatory medication. (p. 18).

Dr. Neal agreed that Petitioner should have a repeat bilateral EMG but opined that Petitioner should attempt bilateral tennis elbow straps and long arm splinting. (p. 39). Dr. Neal would also inject the left elbow a third time and continue the anti-inflammatories. (p. 30). The

Arbitrator notes that the left elbow of Petitioner has not responded to two injections, physical therapy, counterforce strapping, activity modification and medication.

The Arbitrator finds the treatment recommendations of Dr. Nigro, to the extent that they differ from those of Dr. Neal, to be more consistent with the evidence and more persuasive than those of Dr. Neal.

The Arbitrator finds that the Respondent shall authorize payment for the treatment prescribed by Dr. Nigro to the left elbow and to the right elbow.

ORDER OF THE ARBITRATOR

The Petitioner has proven by a preponderance of the evidence that he sustained accidental injuries that arose out of and in the course of his employment, that his current condition of ill-being is causally related to the injury and that he provided timely notice of the accident within the time limits stated in the Act.

The claim for temporary partial disability compensation from April 1, 2013 through October 8, 2013 is denied.

The Respondent shall authorize and pay for the treatment recommended by Dr. Nigro which includes an updated EMG, a left lateral epicondylar release, a left cubital tunnel release pursuant to the EMG results and conservative care to the right elbow.

Richard K. Simpson — Signature of Arbitrator

May 23, 2014 — Date

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

Crystal Mann,

Petitioner,

vs.

NO: 12 WC 32358

15IWCC0018

Petersen Health Care,

Respondent,

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 2, 2014 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.

15IWCC0018

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $3,800.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JAN 12 2015

MB/mam
o:11/20/14
43

Mario Basurto

David L. Gore

Stephen Mathis

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

MANN, CRYSTAL
Employee/Petitioner

Case# **12WC032358**

15IWCC0018

PETERSEN HEALTH CARE
Employer/Respondent

On 6/2/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% 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:

LAW OFFICES OF PHILIP C DENTON
1716 S BROADWAY
ST LOUIS, MO 63104

1337 KNELL & KELLY LLC
PATRICK J JENNETTEN
504 FAYETTE ST
PEORIA, IL 61603

15IWCC0018

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)

CRYSTAL MANN
Employee/Petitioner

v.

PETERSEN HEALTH CARE
Employer/Respondent

Case # 12 WC 32358

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 **Mt. Vernon**, on **April 8, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☐ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☐ Is Petitioner entitled to any prospective medical care?
L. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☒ Other **Is Petitioner entitled to prospective medical under Section 8(a)?**

FINDINGS

On the date of accident, **January 13, 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.

Petitioner has **not** reached Maximum Medical Improvement and has **not** received all reasonable and necessary medical services as required under Section 8(a).

In the year preceding the injury, Petitioner earned **$13,711.23**; the average weekly wage was **$231.17**.

On the date of accident, Petitioner was **32** years of age, ***single*** with **2** dependent children.

Petitioner is entitled to 86 weeks of TTD payments from January 14, 2012 to September 8, 2013 for a total of **$19,880.62.**

Respondent shall be given a credit of **$16,181.90(70 weeks)** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$16,181.90**.

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 $231.17/week for 86 weeks, commencing January 14, 2012 through September 8, 2013, as provided in Section 8(b) of the Act.

Respondent shall authorize and pay for further medical treatment and care as authorized pursuant to Section 8(a) for Petitioner's left shoulder injury recommended by Petitioner's treating physician Dr. McIntosh, and including another orthopedic physician for a second opinion concerning her left shoulder injury, pain management treatment, physical therapy, diagnostic testing and evaluation including arthroscopic examination and surgery, and a TENS unit. Any additional treatment or services recommended by another orthopedic physician seeing petitioner for a second opinion shall also be authorized and paid for by the respondent Such authorizations and payment shall be made promptly and without delay.

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.

regained full ROM (Dp 41).

CROSS: On MRI you can see some decreased shoulder joint space because of adhesive capsulitis/scarring (Dp 54). Dr. did not recall see Dr. McIntosh's 6-28-13 note (Dp 54). The PT records after his 10-4-12 IME show P did have a full ROM (Dp 56)(*NOTE: there are no PT records in evidence after 8-31-12).

ANALYSIS

In my opinion, §12 Dr. Petkovich is disingenuous with his 6-20-13 report opinions. Dr Petkovich gives no basis for opining the FCE is a very inaccurate evaluation of P's abilities and that P had reached MMI. In his 6-20-13 report, Dr. Petkovich noted he had reviewed PT records and FCE and that based on the additional records made available for review that P had recovered from the left shoulder condition and she should not need any further treatment for her left shoulder condition at this time. I see no PT records in evidence after 8-31-12. P did not testify to having PT after the 10-4-12 Dr. Petkovich §12 eval. On 1-24-13, Dr. McIntosh does note that P was attending work conditioning program. Dr. Volarich opined P was not at MMI. Tx Dr. McIntosh opined P had not reached MMI.
-Staff Attorney Recommendation: A & A Arb's Decision. I see no reason to not do so.

15IWCC0018

Signature of Arbitrator

6/2/14
Date

ICArbDec19(b)

JUN - 2 2014

15IWCC0018

BEFORE THE WORKERS COMPENSATION COMMISSION
STATE OF ILLINOIS

THE HONORABLE EDWARD LEE

ARBITRATOR

CRYSTAL MANN,	)	
	)	
Petitioner,	)	
	)	
vs.	)	Case No: 12WC32358
	)	
PETERSEN HEALTH CARE,	)	
	)	
Respondent.	)	

DISPUTED ISSUES:

1. Is Petitioner's current condition of ill-being causally related to the accidental injury on January 13, 2012.
2. Has Petitioner reached Maximum Medical Improvement (MMI) and received all reasonable and necessary medical services under 820 ILCS 305 §8(a)?
3. Is Petitioner entitled to temporary total disability benefits from January 14, 2012 to September 8, 2013?

FINDINGS:

1. Petitioner's current condition of ill-being **is** causally related to the work accident of January 13, 2012.
2. Petitioner has **not** reached Maximum Medical Improvement (MMI) and has **not** received all reasonable and necessary medical services as required under § 8(a).
3. Petitioner's TTD rate is $231.17 a week and is entitled to 86 weeks of TTD payments from January 14, 2012 to September 8, 2013, and any future periods of TTD if petitioner is under medical restrictions not to work due to her injuries and until such time petitioner reaches MMI. Respondent is entitled to a credit from TTD payments made from January 14, 2012 to May 20, 2013.

ORDER:

TEMPORARY TOTAL DISABILITY

Respondent shall pay Petitioner temporary total disability benefits of $231.17/week for 86 weeks, commencing January 14, 2012 through September 8, 2013. Respondent shall be given a credit for temporary total disability payments that have been paid from January 14, 2012 through May 20, 2013.

MEDICAL BENEFITS:

Respondent shall authorize and pay for medical treatment and services for her left shoulder/arm injury recommended by Petitioner's treating physician, Dr. McIntosh, and including another orthopedic physician for a second opinion concerning her left shoulder/arm injury, pain management treatment, physical therapy, diagnostic testing and evaluation including arthroscopic examination and surgery, and a TENS unit. Any

additional treatment or services recommended by another orthopedic physician seeing petitioner for a second opinion shall also be authorized and paid for by the respondent. Such authorizations and payment shall be made promptly without delay.

STATEMENT OF FACTS

The Petitioner, Crystal Mann, is a 34 year old woman (DOB: 04/28/1979) who was injured while performing her duties as a nurses aid at the respondent's nursing home facility in Vandalia, IL. Petitioner's injury occurred while she was cleaning a resident with the resident rolled on to her side and holding on the bed rail. The resident unexpectantly let go of the bed rail when she sneezed. Petitioner tried to grab the resident but caught her arm in an awkward position and petitioner immediately felt pain in the neck/left shoulder region.

Immediately following the injury petitioner reported the injury to her employer. Petitioner started treatment at the Wellness Complex in Vandalia, IL on January 16, 2012. Petitioner was evaluated and prescribed analgesics and physical therapy. Petitioner received physical therapy at Fayette County Hospital in Vandalia, IL through February 16, 2012. Petitioner was then released to go back to work with no restrictions Petitioner soon noticed increased swelling and pain about the shoulder radiating up to her neck prompting her to see Dr. Jeffery McIntosh, and orthopedic surgeon. She saw Dr. McIntosh, of Mount Vernon, IL , at a sub office in Vandalia, Illinois beginning February 24, 2012. Dr. McIntosh put her on work restrictions included no lifting, prescribed muscle relaxants, and anti- inflammatory medication. Petitioner's condition did not improve. A TENS unit was prescribed by Dr. McIntosh but was not authorized by the respondent. Dr. McIntosh performed localized injection to the sub-acromial space.

She returned on March 15, 2012 and Dr. McIntosh noted that the TENS unit had not been issued to her. Dr. McIntosh on March 29, 2012 reevaluated the petitioner and ordered an MRI. Petitioner returned to Dr. McIntosh on April 19, 2012 following the MRI testing. The MRI of her left shoulder revealed evidence of a superior labral tear and a labral cyst. Her symptoms had not improved despite therapy, time, and corticosteroid injections and she continued to have significant pain and no range of motion.

Dr. McIntosh performed left shoulder arthroscopy on June 4, 2012 with the postoperative diagnosis of: 1. SLAP lesion of the left shoulder, 2. Glenoid labral tear, 3. Biceps tenosynovitis, and 4. Impingement syndrome. Dr. McIntosh surgically performed : 1. Left shoulder arthroscopy, 2. Debridement of SLAP lesion with biceps tenotomy and debridement of glenoid labral tear, and 3. Sub-acromial decompression with bursectomy and resection of the coracoacromial ligament. Dr. McIntosh prescribed a regimented rehab program and petitioner made progress on reevaluations on July 12, 2012. On August 9, 2012 on another reevaluation of her left shoulder petitioner did not feel she was improving much. She could lift her arm but she felt the catch when it comes down. She made some progress in physical therapy but it waxed and waned. Her current work capacity at that time was no work above her chest or shoulders and right handed work only.

On September 6, 2012 Dr. McIntosh reevaluated the petitioner. She was found to have hit a plateau with physical therapy and was not improving. Repeat MRI was ordered. Dr. McIntosh noted that if a cortical steroid injection did not give her relief that she may benefit from open decompression. She again saw Dr. McIntosh on September

27, 2012 following the MRI of her left shoulder. Dr. McIntosh at that time did not consider her to be at maximum medical improvement.

Respondents scheduled an IME on October 4, 2012 with Dr. Petkovich. Petitioner returned to Dr. McIntosh on January 24, 2013 following the Respondent's IME which recommended continuing strengthening programs and a work hardening program. There was a total of 18 visits with physical therapy in the interim. Dr. McIntosh at that time, at the conclusion of the physical therapy prescribed by the respondent IME physician, Dr. Petkovich, found significant weakness in her shoulder. She was only able to abduct actively to approximately 40 or 45 degrees and her flexion was approximately 170 degrees but was painful for her to come to the flex position. Abduction is painful and she had significant pain on internal and external rotation actively. Passively she had full flexion, Petitioner had 120 degrees abduction but is was painful for her. Petitioner was to continue her work conditioning programs and she was given a cortical steroid injection at that time.

On March 7, 2013 Dr. McIntosh reevaluated her following petitioners participation in the work conditioning program. She was able at that time to finally obtain a tens unit without the assistance of the Respondent. Dr. McIntosh at that time recommended a functional capacity evaluation (FCE) and suggested petitioner see a physiatrist or pain medicine specialist. The FCE was performed at Nova Care Rehabilitation on May 9, 2013. The FCE found her suitable for light or sedentary work. By this time respondents EMI physician, Dr. Petkovich, had issued an addendum to his initial report without reevaluating petitioner in person, and placed her at maximum medical Improvement and stated petitioner could return to her job as a CNA.

On June 28 2013 Dr. McIntosh noted in his records he attempted to send petitioner to a pain management and "we have tried to work with workman's comp in finding a suitable pain management doctor for her". She continued to complain of pain, decreased range of motion, and dysfunction with her shoulder. Petitioner remained on analgesic medication. Dr. McIntosh's evaluation on June 28, 2013 revealed that petitioner had pain during range of motion, specifically with forward flexion, abduction, internal rotation, and external rotation. Petitioner was found to be able to flex to 70 degrees before onset of pain. Internal rotation and external rotation were both painful for her. Dr. McIntosh noted that petitioner did not feel that she could return to her job as a CNA or an EMT. Dr. McIntosh noted that petitioner may benefit from an examination under anesthesia and repeat arthroscopy which he believed to be a reasonable option if he could not get her into a pain management program. Petitioner was noted to state that her shoulder had been getting worse and finds it very difficult to lift anything.

Petitioner testified that respondent has refused authorization of any of Dr. McIntosh's recommendations including a refusal to allow an arthroscopic examination or pain management, or to see a physiatrist. Petitioner also testified that she wants to follow through with these treatments in order to relieve her pain and discomfort and to obtain better range of motion.

CONCLUSIONS OF LAW

WITH REGARD TO DISPUTED ISSUE NUMBER 1 "IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE

ACCIDENTAL INJURY ON JANUARY 13, 2012?" THE ARBITRATOR RENDERS THE FOLLOWING FINDINGS OF FACT AND CONCLUSIONS OF THE LAW:

The petitioner was injured in an accident that arose out of and in the course of the petitioner's employment with respondent as a nurses aid. The petitioner testified that she was working for the respondent at Petersen Health Care facility in Vandalia, Illinois on January 13, 2012 as a nurse's aid. On that day petitioner was injured while attempting to clean a patient that had been turned on her side. The resident patient unexpectedly let go of the bed railing resulting in a force applied to petitioner's left arm and left shoulder while in an awkward position. Petitioner immediately felt an injury to her left shoulder area. Petitioner reported the injury and sought on site medical treatment for her injury. Petitioner received conservative treatment at the Wellness Complex in Vandalia, Illinois. Petitioner subsequently sought treatment with Dr. McIntosh, an orthopedic surgeon for further treatment. Dr. McIntosh ordered physical therapy, performed steroid injections, and performed arthroscopic surgery on her left shoulder. Objective evidence of injury was identified both on MRI and during surgery in June 2012. Petitioner consistently complained of pain and decreased range of motion and weakness in her left shoulder. Petitioner testified at trial about her medical history and current complaints. Petitioner introduced at trial supporting medical evidence through Dr. McIntosh testimony and Dr. Volarich's deposition testimony. Both of these doctors testified that her injury and left shoulder condition were caused by the accident occurring on January 13, 2012. Even respondent's IME physician, Dr. Petkovich, testified that her left shoulder injury and need for surgery was caused by the work accident on January 13, 2012. The respondent produced no evidence at trial to suggest

a mechanism of injury or cause other than the January 13, 2012 work injury, or competent expert testimony that petitioner's current condition was related to anything other than the January 13, 2012 work injury. Petitioner's current condition of ill-being is causally related to the January 13, 2012 work injury with the respondent.

WITH REGARDS TO DISPUTED ISSUE NUMBER 2 "HAS PETITIONER REACHED MAXIMUM MEDICAL IMPROVEMENT (MMI) AND RECEIVED ALL REASONABLE AND NECESSARY SERVICES UNDER 820 ILCS 305 §8(a)? THE ARBITRATOR RENDERS THE FOLLOWING FINDINGS OF FACT AND CONCLUSIONS OF LAW:

Petitioner received orthopedic medical treatment from Dr. McIntosh on her left shoulder which included steroid injection, physical therapy, arthroscopic surgery, work hardening, FCE, and pain medication. Petitioner is currently on prescribed pain medicine. Dr. McIntosh testified that "she started her treatment with the major complaint of pain, and I don't believe her number one complaint has been taken care of. I think she still has pain". Further, Dr. McIntosh testified, "The way I look at maximum medical improvement is that no matter what treatment is provided, she's not going to show any improvement, and I don't think she's at that point. I don't think that she's as good as she's going to get." Further, I think she can get better"... "I just may not be the guy that can get her there." Further, "She's not at MMI at this time." Dr. McIntosh stated that its his opinion that even though he can't explain anatomically where the pain is coming from that there is no question in his mind, within a reasonable degree of medial certainty, that it's all related to the original injury that she had and its legitimate. Dr. McIntosh testified that his recommendations would be (1) an objective evaluation from a

fresh set of eyes, (2) if continuing treatment with him, examining her under anesthesia. (3) if he can't find a great source for the pain, then the pain doctors may be able to find the source for the pain, and do something to try to alleviate the pain. Pain management would be an option. Dr. Volarich testified similarly as Dr. McIntosh. Dr. Volarich testified that petitioner is not at maximum medical improvement. He recommended an MRI arthogram of the left shoulder. A cortisone injection was recommended in addition to pain management and repeat surgical evaluation. He recommended that Petitioner see Dr. Michal Muline or Dr. James Emanuel for additional evaluation and treatment. He testified that her severe pain and lost motion was consistent with at least a frozen shoulder and recurrent labral tear.

Respondent's IME physician, Dr. Petkovich, saw petitioner for evaluation on October 4, 2012. At that time he agreed she was not at MMI and recommended additional physical therapy. At the conclusion of the physical therapy, without seeing Petitioner again for re-evaluation, issued an addendum report on June 20, 2013 stating petitioner was at MMI. The pain and decreased range of motion that Dr. Petkovich found in October 2012 when he concluded she was not at MMI, was still present after the physical therapy he prescribed and as documented by Dr. McIntosh on June 28, 2013.

Accordingly, Petitioner is **NOT** at Maximum Medical Improvement and has **NOT** received all reasonable and necessary medical services as required under §8(a).

WITH REGARD TO DISPUTED ISSUE NUMBER 3 "IS PETITIONER ENTITLED TO TEMPORARY TOTAL DISABILITY BENEFITS FROM JANUARY 14, 2012 THROUGH

SEPTEMBER 8, 2013?", THE ARBITRATOR RENDERS THE FOLLOWING FINDINGS OF FACT AND CONCLUSIONS OF LAW:

Respondent does not dispute that petitioner is entitled to TTD benefits from January 14, 2012 through May 20, 2013. The weeks in dispute are from May 21, 2013 through September 8, 2013.(when petitioner found alternative employment that could reasonable accommodate her disability).

Dr. McIntosh's restricted Petitioner to no work on 1/23/2013 and on 7/1/2013 restricted her to no work above chest and shoulder, no lifting, and unavailable by employer then off work. Respondent stopped TTD benefits as of 5/20/2013. Dr. McIntosh's work restrictions were essentially unchanged since the time of petitioner's work injury. Respondent has not offered any evidence that employment was offered to petitioner to accommodate her restrictions. Since petitioner had not reached MMI according to Dr. McIntosh and Dr Volarich, TTD benefits should have continued up to the time petitioner found alternative employment on September 9, 2013. Accordingly, petitioner is entitled to TTD benefits of $251.17/week from 1/13/2012 through 9/8/2013 or 86 weeks.

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

Myon Sims,
Petitioner,

vs.

NO: 08 WC 02016

15IWCC0019

Freeman United Coal Mining Co.,
Respondent.

DECISION AND OPINION ON REVIEW

Petitioner and Respondent appeal the decision of Arbitrator Dearing finding Petitioner suffered from an occupational disease arising from exposure to the hazards of coal mining on August 29, 2007 and he was disabled within the statutory time frame. The Arbitrator found that Petitioner's average weekly wage is $1,056.79. Petitioner failed to prove a wage differential under §8(d)1. Petitioner is permanently partially disabled to the extent of 10% man as a whole. The Issues on Review are whether Petitioner's claim falls under §§1(d)-1(f) of the Occupational Diseases Act, whether Petitioner sustained an occupational disease arising out of and in the course of his employment or which has become aggravated and rendered disabling as a result of the exposure of his employment, whether there is a casual connection between his current condition of ill-being and the exposure on August 29, 2007, and if so, that amount of Petitioner's average weekly wage and the nature and extent of Petitioner's permanent disability. Lastly, whether Petitioner persisted in an injurious practice under §19(d) of the Act. The Commission, after reviewing the entire record, reverses the Arbitrator's decision and finds while Petitioner complied with §1(f) of the Act, Petitioner failed to prove he sustained an occupational disease arising out of and in the course of his employment or which has become aggravated and rendered disabling as a result of the exposure of his employment and he failed to prove there is a causal connection between his current condition of ill-being and the exposure on August 29, 2007. Petitioner did not violate §19(d) of the Act.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission finds:

1. Petitioner testified he is 58 years old. He never graduated from high school and never obtained his GED. He worked as a coal miner for 31 years and worked 20 years underground. He was regularly breathing in coal dust and was exposed to silica dust and glue fumes from roof bolting and diesel fumes. He last worked in the mines on August 29, 2007. He was 51 years old on that date. August 29, 2007 was his last day because the mine closed. He went on the recall panel so he could be called back. As far as he knows he is still on the panel. In addition to breathing problems, he has congestive heart failure. He applied for and is receiving Social Security Disability (SSDI) benefits based on his breathing problems, congestive heart failure and the deep vein thrombosis (DVT) of his right leg. He has had breathing problems since the mid 1990's when he was working as a rock duster spreading dust on the face, ribs and floor of the mine to prevent explosions and fires. In 1996, he was working when they dropped a load of dust on him. After this incident, his primary care physician prescribed an inhaler for his breathing problems and sent him to Dr. Parbhu, a specialist. Two years later he bid on another job to get away from the rock duster job. His cardiologist made a recommendation regarding his workplace and the company did not honor it. His breathing problem gradually got worse. He bid on other jobs because he was having breathing problems and those accommodations were met. He did not leave the mine after the accommodations because he did not have the education, he needed insurance, he has a family and there was nothing better around. After he left the mine, he looked for work in a couple of places but he did not receive any responses. After that, he applied for and received SSDI. His other work history consists of running a machine for Sangamon Paper Company. While in the mine, he would experience shortness of breath (SOB). He had problems since the '96 incident. Since he left the mine, his breathing problems are about the same. He can probably walk 50 yards outside on level ground and climb 5 steps before he had to stop and rest. He is not presently using any breathing medication. When he worked in the mine, he would occasionally use inhalers. He can no longer walk and in light of his breathing problems. He does not believe he could work in the mines. He has been smoking since his early 20's. He averages ½ a pack per day. He also has a couple of herniated lower discs. If offered a coal mining job today, he would not want to be in those conditions and he could not physically perform the work. In 2013-2014, the rate of pay is $27.40-$27.42 or something like that. On cross examination, Petitioner testified that but for being laid off, he would you have reported to his next shift. Shortly after he last stopped, he began collecting unemployment benefits and he collected them up to the time he started receiving SSDI in December of '07. He also applied for and received his full retirement pension on November 1, 2007. It was not a disability pension. He only listed a truck job on the panel. While he attributes the '96 incident of being covered up with dust as a factor in his breathing problem, he never filed a claim for that incident. The reason he bid for the outby position in '05 was because of his vascular issues. Respondent

accommodated him. He does not know what conditions allowed him to receive SSDI benefits. He last used the breathing medication shortly after the '95 incident. He does not remember if his W2's reflect a clothing allowance, money for Cobra, vacation pay. His SSDI started in February of '08. He filled out the panel because he thought it was the only job he could do, he had done this job in the past and the job would be on the surface.

2. The Petitioner's pertinent medical records are as follows:

On March 15, 1995, Petitioner was seen by the company health facility. The Petitioner came in for an evaluation. It was noted that he was working as a coal miner when a whole load of dust was dumped on top of him and he was totally covered with dust. He reports that since then he had had difficulty breathing and he has had a cough. He is coughing out a white dusty sort of sputum. On physical examination, his breath sound diminished bilaterally and occasionally scant wheezes are heard. His pulmonary function tests show a mixed restrictive and obstructive pattern with low diffusing capacity suggesting an interstitial component. Petitioner was diagnosed with acute bronchitis and pneumonitis secondary to dust exposure. Petitioner was advised to quit smoking. He was prescribed an inhaler and instructed to follow up on the pulmonary function tests (PFTs). Petitioner's March 16, 1995 chest x-rays were negative. Petitioner underwent pulmonary function studies on March 15, 1995, March 24, 1995 and April 18, 1995.

On March 24, 1995, Petitioner was seen at the Springfield Clinic for a follow up visit. He felt a little improved but he did not feel all the way better. He is still coughing a little and has some exertional dyspnea but no chest pain and no other symptoms. Petitioner was told to continue reducing Prednisone to 15 mg a day for a week and then reduce by an additional 5 miligrams once a week prior to quitting altogether. He was told to continue using the Ventolin inhaler. He was advised to quit smoking. The doctor released him to return to work and told him to follow up in three weeks to repeat the pulmonary function and diffusing capacity tests.

On April 26, 1995 Petitioner was seen at Springfield Clinic. It was noted that he has pneumonitis secondary to dust exposure when he had an accident in the mine and was inadvertently buried under an avalanche of dust. His PFT's at that time showed restrictive lung disease with low diffusing capacity but they improved with a short course of Prednisone and a Ventolin Inhaler. His recent pulmonary function tests are satisfactory. Patient has been advised to stop smoking. He is totally asymptomatic at the moment and reports no dyspnea. He was discharged from further follow up and advised he should never again resume the habit of cigarette smoking.

On September 5, 1995 Petitioner was seen at Springfield Clinic. He is complaining that ever since the dust exposure incident he is still SOB with exertion. He claims he has not smoked since April. The last PFTs looked pretty good with just a 6% response to

broncholdilator. On physical examination his lungs are clear. Petitioner was told to start with a room air and exercise oximetry test. If this is completely normal, then we may try him on Beclovent and see him in two weeks. A ventilation perfursion lung scan might be considered.

On September 25, 1995, Petitioner was seen at the Springfield Clinic. They went over the PFT's. There clearly has been an inflammation probably from the dust exposure that then improved with steroids. The oximetries at rest and with exertion were normal. We do not know what the C02 did because as Dr. Prabhu pointed out the AA gradient may have widened with exercise which might support vascular insufficiency. Dr. Prabhu suggested a metabolic stress test. On exam today, his lungs are clear. There are no wheezes even on forced expiration. We will see about doing metabolic stress test. For now, we will have to bill this as workers' compensation Petitioner still is not smoking and has abstained since April.

On October 5, 1995, Petitioner was seen at Prairie Cariovascular. A supervised cardiopulmonary exercise study was conducted on the Petitioner who apparently has been experiencing SOB following an accidental dust exposure at work. There are no significant pulmonary limitations on exercise, but his test demonstrated steep heart rate response curve compatible with de-conditioning.

On November 3, 1995, Petitioner was seen at Springfield Clinic where he reported that he is still not happy with his breathing and says he is SOB with exertion. Unfortunately, he started smoking again. They went over the metabolic stress test results and it showed just de-conditioning. He brought in some papers that showed the contents of the dust he was exposed to and there is some silica in there. He has been working with that for years but it was just this one exposure that was pretty heavy earlier this year. Since that time he reports he has been SOB. We did not examine him today because we did not feel it was necessary. He will get another set of PFTs today and if they show noting I'm going to have him see Dr. Prabhu. The November 3, 1995 pulmonary function studies showed a normal flow rates with normal FRC, TLC and measured inspiratory capacity. The calculated expiratory resolve volume was also within normal limits. The diffusing capacity limit is at the lower limit of normal and likely representing the effect of cigarette smoking although severe anemia, pulmonary embolatic disease and pulmonary vascular disease could also mimic this picture. The slightly low residual volume is the only abnormal finding but even this has improved when compared to patient's prior test of April '95.

On January 22, 1996, Petitioner was seen at Springfield Clinic where he reported that he has suffered exertional dyspnea since March of 1995 when he received extensive dust exposure at work. Since then he has had difficulty breathing. The clinical diagnosis at that time was coal dust pneumonitis. He has been treated with steroids and appears to

have improved. However, he continues to complain of exertional dyspnea. He admits to cigarette smoking. He denies chronic cough and has no sputum production. In March of '95 his flow volume showed an FEV-1 of 3.5, improving to 4.06 after inhaled bronchodilator with an obstructed picture. His diffusing capacity measurement was 73% of predicted. Ten days later his FEV-1 was 4.35 or 96% of predicted. Diffusing capacity has improved to 32.2 or 94% of predicted. Subsequent pulmonary function test done in November of 1995 showed essential flow rates at the lower limits of normal and a slightly low diffusing capacity raising the possibility of severe anemia, pulmonary embolic disease or pulmonary vascular disease. In order to further define the situation the patient underwent a cardio-pulmonary exercise stress test. This was initially interpreted to be compatible with de-conditioning. His measured FEv-1 was 3.7. His predicted max ventilation was 130 liters per minute. The doctor recommended an echocardiogram for the heart.

On January 26, 1996, Petitioner was seen at Prairie Cariovascular. He reports his medical problems started approximately twenty years ago when he recalls developing SOB. His pulmonary angiogram demonstrated in conjunction with SOB, pleurtic chest pain and hemoptysis there was a finding of a pulmonary embolus. Some two years prior he had had a DVT and now he has a chronically swollen right leg .Six months ago he was involved in mining accident where he suffered acute dust exposure with acute exacerbation of SOB which has taken him some months to recover from. Currently he presents with SOB that appears temporarily related to acute dust exposure as part o a mine accident.

A March 22, 1996 letter from Dr. Jennison, a cardiologist, stated Petitioner is having problems of SOB for which he is currently being evaluated. He would like to suggest that based on Petitioner's symptomatic response that his current placement in the mine be changed from off-side shuttle car to on-side shuttle car as he is experiencing respiratory symptoms associated with the exhaust fumes from the miners.

On March 14, 1997, Petitioner was seen at Springfield Clinic. It was noted that Petitioner presents today with cough, postnasal drainage which is thick and green in color. He smokes approximately one pack of cigarettes per day. He was successful at quitting for six weeks but then went back to smoking. The cough is nonproductive. There is no pain in chest during cough and he denies any SOB or wheezing. Petitioner was diagnosed with sinusitis and phyngitis which possibly extends into the tracheitis.

A November 10, 1998 Department of Health and Human Services chest x-ray shows atelectasis, unspecified type, calcifications and fibrosis.

On July 27, 2004, Petitioner was admitted into St. Vincent's emergency room. The Petitioner was complaining of a cough and he was coughing up green-yellow phlegm,

had a fever, chills and fatigue along with pain between his shoulder blades. His chest x-ray was negative. On discharge, his cough was almost completely resolved. A follow-up chest x-ray was done on July 28th and it was negative for infiltrates. Petitioner was diagnosed with bronchitis, and a viral syndrome.

On February 8, 2007, Petitioner saw Dr. Rangaswamy who noted that Petitioner denies he is experiencing SOB or a chronic cough. His chest is clear to auscultation. Petitioner's February 23, 2007 chest x-ray indicated Petitioner's lungs were clear and he had multiple scattered calcified granuloma. On January 10, 2008 Petitioner was seen by Dr. Rangaswamy. At that time Petitioner denies experiencing SOB, dyspnea on exertion or a chronic cough. His chest was clear to auscultation. On September 4, 2009 Petitioner was seen at the Springfield Clinic Eye Institute and he provided a history in which he denied any respiratory problems (asthma, SOB, emphysema). On September 3, 2010 Petitioner was seen at the Springfield Clinic Eye Institute where he provided a history of respiratory problems (SOB, cough, wheezing, congestion).
On February 7, 2012, Petitioner was seen at Prairie Cardiovascular where he denied experiencing a chronic cough, hemoptysis or snoring. His chest was clear to auscultation. On September 18, 2013 Petitioner was seen at Springfield Clinic and it was noted that his lungs were clear. On February 12, 2014, Petitioner provided a medical profile to the Springfield Clinic. Petitioner noted under past history that he has had acute bronchitis with brochospasm, varicose veins, blurry vision, pulmonary embolism, hyperlipidemia, snoring, abnormal electrocardiogram, osteoarthritis in ankle/foot, mixed hyperlipidemia, palpitatios, acute periodontitis, restless leg syndrome, DVT of lower extremity, visual disturbances, peripheral vascular disease, long-term use of anti-coagulants. He also noted that he is currently an every day smoker.

3. The parties placed into evidence the following chest x-ray reports:

i. NIOSH

5/29/98: Film Quality 1; Film is completely negative;

5/29/98: Film Quality 1: small opacities, primary s, bi mid and Pleural abnormalities consistent with pneuconiosis...comment post inflammatory Ca++ R hilum and lung. Linear fibrosis or atelectocis at L CPL;

5/8/07-2 separate B readers: Film Quality 1; No parenchymal or pleural abnormalities consistent with pneuconiosis.

ii. Dr. Smith:

7/27/04: Film Quality 1: simple CWP with small opacities, primary p, secondary s, bilateral upper, mid and lower zones involved of a profusion 1/1;

7/27/04 Chest CT: Findings in the CT correspond to that seen in the PA and lateral chest films obtained on the same date;

7/28/04: Film Quality 2: CWP with interstitial fibros of classification p/s, mid to lower zones involving bilaterally, of a profusion 1/0; linear streaky density changes in the lung bases, most pronounced in the left anterolaterally likely related to parenchymal scarring and/or mild subsegmental atelectasis, probable old granulomatous calcification in the right hilus and lateral right mid lung, possible small hiatus hernia.

iii. Dr. Anderson:

7/28/04: Film Quality 2-bi scapula overlay: CWP category p/p, 1/0;

12/19/12: Film Quality 2-bi scapula overlay: CWP category p/p, 1/0 cg, pa; refer Petitioner to personal physician for follow up of a small nodule in the right lung.

iv. Dr. Cohen:

10/9/07: Film Quality is a 3 due to underexposed and poor contrast; positive for the opacities of pneumoconiosis at profusion of 1/0 p/q shaped opacities. Symbol cg is checked.

v. Dr. Rosenberg:

10/9/02: Film Quality is a 2-light; lung field was 0/0 with granulomatous changes along with atelectasis changes ;

7/27/04 CT scan: vibasilar atelectasis w/o micronodularity. Granuloma seen in the right upper lobe;

7/27/04: Film Quality is a 2-scapular overlay; lung field was 0/0 with granulomatous changes in right mid lung with atelectasis in the L costophrenic angle;

7/28/04: Film Quality is a 2-scapular overlay & underexposed; lung field was 0/0 with granulomatous changes in the right mid lung laterally with some basilar atelectasis on the left;

2/11/09: Film Quality underexposed; lung field was 0/0.

vi. Dr. Wiot:

7/27/04: Film Quality is a 1: calcified granuloma in the right mid lung field;

7/28/04: Film Quality is a 2-scapular overexposed calcified granuloma in the right mid lung field;

7/27/04: CT scan calcified granuloma in the right upper lung field laterally, a few linear stands present, particularly at the right base;

10/9/07: Film Quality is a 2-underexposed; calcified granuloma in the right mid lung field;

11/25/09: Film Quality 3-grossly overexposed-no evidence of CWP.

4. SSDI

On September 12, 2007, Petitioner applied for SSDI benefits. He started receiving the same in February of 2008.

In his Social Security application he listed his illnesses as congestive heart failure, poor vision in left eye, two herniated discs in his back and a deep vein blood clot in his right leg, foot and ankle. He was asked to explain how his illnesses/injuries limit his ability to work. He answered he was put on restrictive work duty in 2005. Currently, he is limited in most repetitive actions, which he listed as standing,walking, sitting, driving, lifting, bending, twisting, squatting and climbing. He indicated that most of these activities are limited or are not recommendation by the doctors. The limitations apply to and he has great pain in his leg, back and foot. The pain can last for as long as a week. His poor circulation makes these conditions worse. He also reported that he experiences chest pains and he gets tired, feels very weak and has to sit or lay down for an hour or more after he performs any of these activities. When he is on his feet for an hour or so he needs to sit down because of swelling and pain. He also cannot sit too long because it causes his back to hurt. Any strenuous activity or emotional events cause chest pain. He has to lie down or sit and try to calm down in order to get the pain to lessen. He reported that his left eye is blurry all the time. He is on medications for his heart, back and feet. He has to wear special sock on his legs. He takes pain reliever. He has two herniated discs is his back and his right leg condition is permanent. Petitioner reported that he became unable to work due to his illness on August 28, 2007. He stated he stopped working because of his conditions and for other reasons. He reported that his health problems were getting worse and the coal mine where he worked closed down. He reported he is tired all of the time. He experiences chest pain when he is stressed or he works for any length of time. He has back, leg and feet pain all of the time. He does not feel well most of the time and

feels he cannot work at any job. He noted that Dr. Del Valle was the primary doctor he saw for breathing problem after his work accident. He also saw Dr. Prabhu. He was involved in an incident where there was a dust spill at work and after that he was having trouble breathing. The medical records he listed pertained to varicose veins which resulted from his DVT, his heart and his back.

5. DEPOSITIONS

i. 8/17/11 deposition of Dr. Cohen

Dr. Cohen testified that he is the senior attending doctor at Stroger Hospital of Cook County. He is the medical director of the pulmonary physiology and the rehabilitation section. He works in the pulmonary clinic and the occupational medical clinic running two occupational lung disease clinics here and three occupational lung disease clinics per week. He also works at the hospital performing general pulmonary medical consults and he works in the intensive care unit. He is the medical director of the Black Lung Clinic's program at Stroger Hospital. He is the medical director of the National Coalition of the Black Lung and Respiratory Disease Clinic, which is the federally funded clinics that take care of black lung throughout the country. He provides both education and training to those facilities. He has been a B-reader since 1998. The National Institute of Occupational Safety and Health (NIOSH) oversees the B-reader program. He has served as a panel member or presenter at NIOSH conferences.

He testified that when patients come into our hospital, they are charged for a clinical visit to the hospital. He, personally, does not get paid anything. When he reviews outside records from a patient he charges $250.00 an hour, which gets paid into our research fund and is not taken as income by himself. He derives no income from the deposition. Any income he generated from the deposition goes into the Occupational Medicine Research Fund.

Dr. Cohen states that when he reads an x-ray for coal workers' pneumoconiosis (CWP) there can be a rather subtle difference between 0/1 and 1/0. Those abnormalities/shadows we see on the chest x-ray occurring in a coal miner likely represent areas of dust deposition in the lungs that have been transformed into scar tissue. In order for a person to have pneumoconiosis they must have a tissue reaction to the coal dust that is trapped in the lungs. The lung disease from CWP takes the form of fibrosis which leads to scar tissues which pull apart the adjacent lung and lead to focal emphysema. Usually people start developing CWP after a minimum of ten years of exposure. Emphysema causes an obstructive impairment. People who have CWP often have a fair amount of focal emphysema. By definition, if a person has CWP, they have a lost normal functioning of the lung tissue. If a person has mainly airway toxicity and emphysema, it would be predominantly obstructive and if they have interstitial lung

disease, it would be restrictive. Patients with CWP often complain of SOB. Someone can have a lobe of one lung removed and still be within the normal pulmonary function limits. NIOSH has recommended using NHANES III over Crapo or Knudson standards. He reviewed the respirator chapter for the 5th ed. AMA Guides to Permanent Impairment before it got published. The AMA is probably going to be using the NHANES III, which is very representative of the U.S. population as a whole. The diffusion capacity is a very important test because it measures the ability of the lung to transfer gas from the air sacs into the bloodstream, which is the main function of the lung. So if someone has damaged air sacs or the loss of lung tissue they will not be able to transfer an appropriate amount of carbon monoxide into the bloodstream. A reduced diffusion capacity is a direct measure of obliterated capillary beds. CWP causes destruction of the lung and obliteration of the capillary beds. The third measure of lung function would be the measurement of the actual blood gases. It is an important measure of the lungs' ability to transfer gas. CWP can be considered a progressive disease. It has no cure and it is permanent.

Besides coal dust the miners are subjected to dust that comes from rock strata above and below the coal seam. There is also rock dust which is a nuisance dust that can cause significant lung irritation. There are bio-aerosols that are bio organisms/fungi, algae that mix with the water that is used to cut the coal and these as well can cause hyper-reactive airway disease and loss of lung function. Occasionally, there are hydraulic lines breaks the cause aerosolized hydraulic fluid. There is diesel exhaust in the mines which is also a significant respiratory hazard and a pulmonary carcinogen. In some older mines there is also asbestos.

The best way for a man to avoid his x-ray progression to 1/0 would be that he avoid any exposure to any pulmonary toxins, including coal and silica dust, other respiratory hazards and tobacco smoke. He would not recommend that Petitioner continue to be expose to coal mine dust. CT scans are not recognized by NIOSH for the purposes of making B-readings for pneumoconiosis. Nor are CTs part of the Department of Labor exam for CWP.

In terms of Petitioner's past medical history, Petitioner has complained of SOB for 20 years. He first noticed it with strenuous exercise. It progressed gradually until he saw him. When he saw the Petitioner, he was complaining of SOB after walking two blocks and walking one flight of stairs. He also complained of a cough for 20 years that was not productive. It was more frequent and it progressed over the years. He had no other significant pulmonary symptoms. His past medical history was significant for congestive heart failure, a pulmonary embolism, deep venous thrombosis and herniated lumbar discs. Petitioner was taking Albuterol, Serevent and QVAR, which are bronchodilators and inhaled corticosteroids. They are prescribed for obstructive lung disease including asthma, chronic bronchitis and COPD. CWP can result in obstructive

lung disease. On physical examination, Petitioner had normal auscultation and percussion. His February 11, 2009 chest x-ray was a Quality 3 due to underexposed and poor contrast, which impairs his ability to diagnose pneumoconiosis but not to the extent that it is completely unreadable. It showed it was positive for the opacities of pneumoconiosis at profusion of 1/0 p/q shaped opacities. Symbol cg is checked. The pulmonary function testing at rest showed normal spirometry and normal lung volumes. It also showed mild diffusion impairment with a low DL/Va, which can be seen with CWP. The blood gasses at rest were normal. Petitioner is a man with 31 years of coal mine employment and coal mine dust exposure, mainly with symptoms of dyspnea and dry cough. He was not subjected to an exercise test on the advice of his doctor because of his pre-existing heart disease, his musculoskeletal limitation and his leg problems. So he only did aresting pulmonary function testing. Based on the positive chest x-rays for pneumoconiosis and his exposure history, he believes Petitioner has CWP. He does not meet the diagnosis for chronic bronchitis. He felt Petitioner's chronic cough was due to his coal mine dust exposure. Dr. Cohen agreed that congested heart failure can cause SOB and it can compound lung problems. In advanced lung disease there sometimes is a co-existing congestive heart failure where there is an aggravation by the lung and by the heart to the lung. He had a measurable diffusion impairment that can be related to CWP or his 48 years of tobacco smoke exposure. He has clinical symptoms and complaints of pulmonary impairment that are related to the coal mine exposure because of his CWP. He has radiographically apparent abnormalities that are consistent with pulmonary impairment and are related to his coal mine dust exposure. From a pulmonary standpoint he would be capable of some employment. There is no data to support the fact that coal mine dust cannot cause a chronic and persistent cough. One can have radiographically significant CWP despite having normal pulmonary function tests, normal blood gases and a normal physical examination of the chest. CWP is a very gradual and insidious onset to the disease. The only way to know if a person has a lung disease that progression would be by serial specific PFTs.

On cross-examination, Dr. Cohen agreed that from the late 1990s to 2008 he has performed on average of 20 medical/legal exams for Petitioners' attorneys. He has acted as an unpaid consultant for the United Mine Workers. He did not review any treatment records for this Petitioner. He agreed that treatment records are valuable in evaluating a patient for an occupational disease. He agreed that SOB with exertion has many causes such as de-conditioning and heart disease. He agreed that a cough is a nonspecific symptom. He agreed that smoking, if it results in COPD, can be associated with SOB and if smoking causes chronic bronchitis, it can be associated with a cough. He agreed that Petitioner has a significant and continuing history of tobacco use. When he saw him, Petitioner was smoking 1-1/2 packs of cigarettes per day. With continued tobacco use, he would expect a progression in his symptoms. His reading on both the February 11, 2009 and May 28, 2009 x-rays was the same. He agreed that there was no lower profusion than the 1/0 he assigned. He agreed that there can be no lower profusion rating on a film than

1/0 where it can still be positive for CWP. Based on the statistics from NIOSH's CWP x-ray surveillance program, approximately 3% of Illinois coal miners develop CWP. He agreed that chest x-ray abnormalities are likely to present years before the last date Petitioner worked. If his 02 saturation on room air was 92%, it was low normal. He agreed that Petitioner did not say he left coal mining due to respiratory problems or at the advice of a doctor. Additionally, Petitioner did not say he was unable to perform the duties of his last job in the mine. He agreed that, more likely than not, a coal miner's CWP will not progress once the exposure ceases. He cannot say that Petitioner's CWP will progress. His spirometry lung volumes of diffusion were mildly impaired. There are many causes for this. He agreed that if the patient had emphysema smoking can be a cause of this. His hypoxyhemoglobin level was abnormally high and this could be consistent with someone that has a pack and a half smoking habit. He diagnosed Petitioner with CWP, chronic cough and congestive heart failure. He stated that Petitioner's treatment records would not change his diagnosis.

ii. 1/10/12 deposition of Dr. Rosenberg:

Dr. Rosenberg testified that after medical school, he did a pulmonary fellowship at National Institute of Health. He is board certified in pulmonary disease, internal medicine and occupational medicine and has a master in public health. He works at Mt. Sinai Medical Center in the pulmonary division. He was the director of intensive care and residency training in internal medicine and is also involved with the pulmonary fellowship training program. He is on the pulmonary staff of the University Hospital of Cleveland and is the Director of Corporate Health, which is occupational medical program. Over the years, he has taught medical students. He is a certified B-reader and has been since 2000. He performs 95% of his exams for the mines. He is a medical advisor for the Social Security Administration and the Industrial Commission of Ohio. He is a member of the Occupational Lung Disease Committee. He has taught pulmonary physiology, pulmonary medicine, respiratory physiology, and pulmonary diseases. He has lectures on interstitial lung disease, chronic obstructive lung disease, pulmonary stress testing, exercise testing and occupational lung disease. He has published in the American Review of Respiratory Disease and the Journal of Respiratory Diseases. He would estimate that 10-20% of his patients have black lung disease.

Dr. Rosenberg testified he reviewed the B-reading of chest x-ray dated July 27, 2004 by Dr. Wiot, reviewed the B-reading chest x-ray dated July 28, 2004 by Drs. Wiot and Smith, reviewed the B-reading chest x-ray dated October 9, 2007 by Drs. Wiot, Smith, Cohen, reviewed the B-reading chest x-ray dated February 11, 2004 by Drs. Wiot, Smith and Cohen, interpretation of the July 27, 2004 CT scan by Dr. Wiot, evaluation of Dr. Cohen from the March 27, 2009, Taylorville Memorial Hospital records, the Prairie Cardiovascular records, the Springfield Clinic records, the Social Security records, Allcare's Orthopedic records, chest x-rays from an unknown source

dated February 11, 2009, the Harrisburg Medical Center October 9, 2007 medical records and the Taylorville Memorial Hospital July 27, 2004 and July 28, 2004 medical records.

He noted Petitioner reported that he started smoking at 20 years of age and was still smoking through the evaluation. He averages 1-1/2 packs of cigarettes per day. Overall, he had a 48 pack a year smoking average. He worked from 1976-2006 in a coal mine.

On physical examination Petitioner's lungs were clear. The February 11, 2009 chest x-ray was felt to be a quality 3 and was said to reveal p/q opacities in all lung zones with a profusion of 1/0. A resting arterial blood gas with a barometric pressure of 755 milliliters of mercury revealed a pH of 7.46, a PCO2 of 32.4 milliliters and PO2 of 109 milliliters. An exercise study was not performed because of Petitioner's history of congestive heart failure and a blood clot.

A review of the records show Petitioner had a small reversible ischemic defect in the distal inferolateral wall near the apex on his myocardial perfusion scan, a venous thrombisis, and noted that Petitioner had been diagnosed as having bronchitis, had been taking Coumadin for 20 years. He complained of SOB on a cardiopulmonary exercise study but no significant pulmonary limitation was found. The diffusing capacity was found to be at the lower limits of normal, likely representing the adverse effects of cigarette smoking. On June 26, 1996, Dr. Jennison noted a 20 year history of SOB along with a mining accident six months before with acute SOB. It was felt that his very significant pulmonary embolism could have caused permanent pulmonary vascular damage, which resulted in his chronic SOB. His January 26, 1996 chest x-ray was interpreted by Dr. Stevens as having granulomatous changes on the right with some strands of fibrosis or lineal atelectasis at the left base. The findings on the left side were echoed in a February 22, 1996 chest x-ray. A ventilation perfusion scan of February 22, 1996 was normal. Persistent symptoms of SOB were reported on March 22, 1996 and it was felt that Petitioner should be placed on the off-side of the shuttle car since he was exposed to exhaust fumes. Petitioner continued smoking despite SOB. On February 8, 2007 SOB was outlines along with some chest pain. On February 23, 2007, the coronary arteries were normal and he had mild left ventricular dysfunction. The February 23, 2007 chest x-ray revealed no active disease. On September 25, 1996, Petitioner's SOB was outlined in addition to DVT, pulmonary embolism and tobacco addiction. He was felt to have acute bronchitis with pneumonitis on March 15, 1995. Sinusitis and bronchitis were outlined on March 17, 1997 and wheezes were heard on exam. He outlined pulmonary tests and reviewed the x-rays as well. His x-ray review is noted above.

Petitioner had the following additional medical conditions. He has an abnormality of the left side of his heart. He has a genetic predisposition for developing blood clots.

These clots can go to the lungs and destroy part of capillary bed within the lungs and in turn reduce the diffusing capacity. Dr. Rosenberg noted that long term use of Coumadin can also have an effect on the lungs.

Dr. Rosenberg noted that Petitioner was diagnosed as having pneumomitis in March of 1995 after being covered with dust in the mine. His medical records show he improved over time. The serial pulmonary function tests demonstrate that a month after the event his pulmonary function tests were in the high 80%-low 90% range.

On cross-examination, Dr. Rosenberg agreed that most patients with simple disease have preserved lung function. He agreed that it is possible to have radiologically significant CWP and yet have a normal pulmonary function tests and no symptoms. A coal miner with simple CWP probably will not know about the CWP until he gets a B-reading. One can lose an entire lobe of the lung and still be in the range of normal on a pulmonary test. B-reading was never developed to be a diagnostic test. NIOSH developed a screening method for recording changes on chest x-rays. That's all it is. The only pulmonary function tests in the whole file that shows reactivity are the first ones. Everything else is normal. So we really do not have a diagnosis of reactive airway disease here. The data does not support any kind of chronic disorder from exposure to coal dust.

iii. 4/23/10 deposition of Dr. Wiot:

Dr. Wiot testified he is a doctor and a board certified radiologist and a diagnostic radiologist. He was a full professor from 1966-1998. He was a director of the Department of Radiology from 1968-1992 and a chairman of the Department of Radiology from 1993-1992. He is a professor emeritus. He read between 50-60 x-rays a day during that time. He is still teaching. He is the past president of the American Board of Radiology, which is responsible for the design and test for someone to become board certified. He has served as an examiner of the board for many years. He is the past president for the American College of Radiology. He was part of the original task force for developing a program to teach about the ILO system and occupational lung disease. He worked with Dr. Nelson who developed the categorical course. Today we refer to those programs as B-reader programs. They designed the educational program that people are given when they come for their training before the B-reading exam. His goal in the weekend seminar is to teach doctors to read x-rays properly and consistently.

Dr. Wiot testified that CWP and silicosis invariably begin in the upper lung fields. If they begin on one side it is most often the right side. It always begins on the top and as it progresses it will move to the mid to lower zones. To accurately diagnosis reading of chest x-ray for CWP you are talking about profusion, opacity type, lung zone and film quality. He does not have any peers engage in clinical practice who have the same

experience he has with the B-reading program. You have to understand what normal is and understanding what is normal only comes with experience. It has to be something that you see thousands and thousands of times so when something is not normal it strikes you right away. He was the past president of the Roentgen Ray Society which is one of two big educational societies for radiology. The other is the RSNA. He also read films for the US Navy Asbestos Medical Surveillance team and the US Public Health Service. He is an editor on several medical periodicals. He used to travel and consult. He writes periodically.

His x-ray review is noted above. He did not review any medical records for Petitioner. He did note that Petitioner has been on an anticoagulation therapy for a long period of time and he believes that the changes seen on the chest x-ray could be consistent with that. Occasionally, the anticoagulant therapy patient will get hypocoagulated and will have hemorrhage in his lungs.

On cross examination, Dr. Wiot testified that CT scans are generally not used as part of the screening for CWP. If the CWP is simple, he cannot put up a chest x-ray and said it is unquestionably CWP. If it is complicated he can most of the time say you better look at the history of exposure to coal dust or silicosis. With an x-ray you are asking me if it is compatible with CWP not whether it is CWP. On reading an x-ray, I do not want to know the person's history. I just want to assume that he has been exposed. I do not want to be influenced by the history. If I am treating a patient, I want to know everything I can about the patient . If someone has CWP the only treatment is removal from further exposure. It is possible to have CWP and yet still have a normal physical examination of the chest and normal pulmonary function testing. The only way the coal miner is going to know he has CWP is having his chest x-ray read by someone.

iv. June Blaine was deposed on November 19, 2013:

June Blain testified that she is a vocational rehabilitation counselor. She evaluated Petitioner on October 1, 2013. She was instructed by Petitioner's attorney to assume that Petitioner would no longer be able to work as a coal miner. She was also instructed to construe the health of this man and his physical limitations most strongly in favor of the coal company and to assume that he did not have physical limitations beyond what a person his age would normally have and that there was no need for her to review his medical records. Ms. Blain testified that Petitioner quit high school before he finished and he never got his GED. He does not know how to use a computer and his wife programmed his cell phone. He worked at Sangamon Paper and then Lockman Steel for no more than two years total in labor type positions. The remainder of his career was at Freeman Coal. None of these jobs gave him any transferable skills. He performed a job search after leaving the mine but he was unsuccessful. On vocational testing he scored a

5.7 in reading, comprehension of 9.9 and a 4.3 for math. Limitations in finding work would be that he does not have a GED/high school diploma. He has worked as a coal miner his entire working career. He is 57 years old. Other than his comprehension, his vocational testing was not even at the high school level. He did not have any computer skills. He required assistance in programming numbers into his phone. He had no transferrable skills. She opined that Petitioner is not employable in the open marked. If he were to find a job, she believes he would be at the minimal level of $8.25 an hour. She was not asked to provide assistance to Petitioner on finding a job. She had no medical records for Petitioner. She knows Petitioner has been on Social Security Disability since 2006 and he last worked in the mine in 2006. She does not know what medical conditions Petitioner claimed were disabling him or the basis for his Social Security Disability award. Assuming Petitioner cannot walk, stand, sit, drive, lift, bend, twist, squat or climb she does not think he could work in any job with those restrictions. The only job she knows that he looked for was working in a salvage yard but he thought that might be too physical for him and he did not apply. Petitioner's 2006 and 2007 W-2s were submitted into evidence.

Based on the above, the Commission finds that while Petitioner complied with §1(f) of the Act, Petitioner failed to prove his claim falls under §§1(d)-1(e) of the Occupational Disease Act. The Petitioner failed to prove he sustained an occupational disease arising out of and in the course of his employment or which has become aggravated and rendered him disabled as result of the exposure of his employment and failed to prove there is a causal connection between his current condition of ill-being and the exposure on August 29, 2007.

The Commission disagrees with the Arbitrator's finding that Petitioner suffers from CWP as a result of his exposure to the hazards of coal mining and that Petitioner has a chronic cough and mild pulmonary impairment related to the same. The Commission disagrees with some of the basis upon which the Arbitrator made her decision. In this claim there are experts on both sides of the issues at hand. The Commission takes exception to two of the comments made by the Arbitrator. Specifically, the Arbitrator noted Dr. Cohen's lack of remuneration for his services and she also noted Respondent's experts having a financial interest in performing examinations for the coal company. In the Commission's mind these are not distinctions that should be used as a basis for assigning more weight to one side than the other. While Dr. Cohen may not see a direct remuneration for his services, the Commission infers that the doctor does not work for free for the hospital and he draws a salary for his services. As such his remuneration comes to him indirectly in the form of a salary as opposed to receiving a direct remuneration for his B-reading. Given the fact that the Commission infers the doctor receives a remuneration, albeit indirectly, it believes that fact places him on an even planning field with the other experts in this case and his opinion should be equally weighed with the other doctors' opinions as opposed to be given a greater

weight. The Commission believes all things being equal the financial interest of the experts should not be a factor in the assignment of weight given to their respective opinions.

Secondly, the Commission finds that the evidence presents a total of four NIOSH B-readers' interpretations of chest x-rays. Three of the four readings are negative for CWP. Of the four readings, only one is questionable. The Commission finds that while one of the four B-readers from NIOSH found the May 8, 2007 chest x-ray showed parenchymal abnormalities consistent with pneumoconiosis, the same B-reader found a 0/2 protrusion rate which is deemed to be negative for CWP and is supported by Dr. Cohen's own testimony that there can be no lower profusion rating on a film than 1/0 where it can still be positive for CWP. Furthermore, the B-readers written commentary at the end of the report parallel the findings made by Dr. Rosenberg.

Thirdly, the Commission believes it is important to note that the subsequent chest x-rays taken after the May 8, 2007 date and reviewed by the two separate NIOSH B-readers and Drs. Rosenberg and Wiot alike were found to be negative for CWP. While Drs. Cohen and Anderson found Petitioner to be positive for CWP, they found a profusion of 1/0, which is the least rating one can have and have it still be positive. Further note that of all the post May 8, 2007 chest x-rays that were reviewed by NIOSH, Drs. Anderson and Cohen and Drs. Rosenberg and Wiot, only two of the NIOSH films were rates as quality 1 films and they were both deemed to be negative for CWP.

Fourthly, and most importantly, Dr. Rosenberg testified that B-readings were never developed to be diagnostic tests. Rather the readings are limited to be only a screening method for changes on chest x-rays. With that said, it is important to look at all of evidence presented and specifically whether or not the doctors reviewed Petitioner's other medical records. The evidence clearly shows that Dr. Rosenberg performed a review of all of Petitioner's medical records while Dr. Cohen did not review Petitioner's medical records and instead he only relied on the history that Petitioner gave regarding his work, symptomatology and medical treatment. On review of the records, Dr. Rosenberg only found one "acute" incident resulting in a diagnosis of coal dust pneumoconitis that was treated and resulted in Petitioner's pulmonary test to return to normal. This same finding was made in/around 1995 which is twelve years prior to the August 29, 2007 shut down of the mine and Petitioner's claim for SOB. While Petitioner claims he experienced SOB from 1995 forward/claims a 20 year history of SOB and Dr. Cohen diagnosed, among other things, a chronic cough, Petitioner's medical records do not support this claim. Rather, they show numerous instances of opposite findings of clear lungs, denial of chronic cough and SOB. Lastly, there are other explanations for the mild low diffusion capacity, which was still found within normal limits. Additionally, the B-readings of Petitioner's chest x-rays by both sets of experts appear to get better and not worse the closer the readings got to Petitioner's alleged disablement date and the most

15IWCC0019

recent x-rays reviewed only three months prior to Petitioner's last date of exposure were negative for CWP. Furthermore, regardless of the experts representation, there is additional evidence contained in the record of independent B-reader interpretations which acts as tie breaker between the paid experts. In the end and after weighing a totality of the evidence, the Commission reverses the Arbitrator's finding that Petitioner suffers from CWP as a result of his exposure to the hazards of coal mining.

The Commission notes that the higher Courts have interpreted the Act and specifically the term disablement to be either a functional disability or an impairment which results in a loss of earning capacity. In terms of the two definitions, the Commission finds above that Petitioner failed to prove his claim of disablement. As the Commission already commented upon, the NIOSH chest-rays taken only three months prior to the mine shut down were read by two separate B-readers and they both found that Petitioner was negative for CWP. Petitioner testified that he bid for semi surface type jobs such as the outby position not because of CWP but because of his vascular issues. The evidence shows that Petitioner stopped working in the mine because it closed down and not because he was disabled to the point where he could no longer work. Petitioner was working up until and including the date that the mine closed down. When Petitioner was asked whether he would still be working had the mine not shut down, Petitioner answered in the affirmative. After the closure of the mine, Petitioner placed himself on a panel to continue working in the mine, albeit on the surface as was his right given his long length of seniority. In addition, Petitioner started collecting unemployment while representing to state of Illinois that he was capable of working. During this time, Petitioner told June Blaine, the vocational rehabilitation counselor, that he looked for one job in a scrap yard but he decided not to apply because he believe it would be too physical in nature. While he testified at Arbitration that he looked for a couple of jobs, he did not provide any specifics regard what, if any, jobs he applied for. Within one month of the mine shutting down, Petitioner applied for Social Security Disability. While the Commission will not repeat the long list Petitioner provided for the basis of his eligibility for Social Security Disability benefits and the Social Security determination, it is sufficient to say that Petitioner's reasons for being eligible were limited to congestive heart failure, poor vision in the left eye, herniated discs in the back and DVT of the right leg with no mention of SOB/a chronic cough or CWP. Note the SOB/chronic cough references only appear in the long list of medical histories Petitioner provided as a basis for his eligibility. Furthermore, Petitioner also put in for and received his "full" pension upon retiring from the mine as opposed to a disability pension. Dr. Cohen testified that Petitioner could from a pulmonary standpoint be capable for some employment. When June Blaine was asked to review Petitioner's circumstances she was told in a hypothetical to assume that Petitioner did not have any physical limitations beyond what a person his age would normally have and she was told there was no need to review his medical record. Yet, Petitioner's medical records show he has congestive heart failure, a history of DVT, etc. Lastly, and most importantly, Pet. is not currently treating for CWP and has

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not received any treatment via a broncholdilator since the "acute" incident back in 1995, 12 years before the mine shut down. In the end, the Commission finds that the evidence does not supports Petitioner's claim that he proved disablement through either a functional disability or suffering an impairment which resulted in a loss of earning capacity.

While Dr. Cohen opined that Petitioner is disabled due to CWP and cannot work as a coal miner because he cannot be exposed to coal dust, Dr. Cohen's also states in his June 3, 2009 report that Petitioner has a mild impairment that does not totally disable him from coal mining employment. Thus, the Commission finds that Petitioner would not have been precluded from working as a coal miner in an above ground position so long as his position no further exposed him to silica/coal mining dust. With that said, the Commission finds that the Arbitrator correctly pointed out the fact that none of the doctors said that Petitioner was unable to perform coal miner work. With this understanding, the Commission further finds that Petitioner would not be able to prove up the first prong of a wage differential award in that he is not prevented from pursuing his usual and customary line of employment. Lastly, the Commission finds that the Arbitrator correctly found that Petitioner did not engage in an injurious practice pursuant to§19(d) of the Act.

IT IS THEREFORE ORDERED BY THE COMMISSION that since Petitioner failed to prove he sustained a disease arising out of and in the course of his employment or which has become aggravated and rendered disabling as a result of the exposure of the employment, his claim for compensation is hereby denied.

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

DATED: JAN 12 2015

Mario Basurto

David L. Gore

Stephen Mathis

MB.jm

O: 11/20/14

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STATE OF ILLINOIS)
) SS.
COUNTY OF JEFFERSON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Mary K. Ticer,
Petitioner,
vs.
Illinois Department of Corrections
Big Muddy River Correctional Center,
Respondent,

NO: 11 WC 34958

15IWCC0020

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, causal connection, medical expenses, permanent partial disability, statute of limitations 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, 2014 is hereby affirmed and adopted.

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

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

No bond or summons for State of Illinois cases.

DATED: JAN 12 2015

Mario Basurto

David L. Gore

Stephen Mathis

MB/mam
o:11/20/14
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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

TICER, MARY K
Employee/Petitioner

Case# **11WC034958**

15IWCC0020

IL DEPT OF CORRECTIONS-BIG MUDDY RIVER CORRECTIONAL CENTER
Employer/Respondent

On 5/15/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% 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:

2500 WOMICK LAW FIRM CHTD
CASEY VanWINKLE
501 RUSHING DR
HERRIN, IL 62948

0502 ST EMPLOYMENT RETIREMENT SYSTEMS
2101 S VETERANS PARKWAY*
PO BOX 19255
SPRINGFIELD, IL 62794-9255

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

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

1350 CENTRAL MGMT SERVICES RISK MGMT
WORKERS' COMPENSATION CLAIMS
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

MAY 15 2014

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

15IWCC0020

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

MARY K. TICER
Employee/Petitioner

v.

ILLINOIS DEPT. OF CORRECTIONS –
BIG MUDDY RIVER CORRECTIONAL CENTER
Employer/Respondent

Case # 11 WC 34958

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

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☒ Was timely notice of the accident given to Respondent?
F. ☒ 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

15IWCC0020

FINDINGS

On **July 6, 2010**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$51,844.00**; the average weekly wage was **$997.00**.

On the date of accident, Petitioner was **50** years of age, ***married*** with **0** dependent children.

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

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

Respondent shall be given a credit of **$6,399.14** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$6,399.14**.

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

ORDER

Respondent shall pay for reasonable and necessary medical services set forth in Petitioner's Exhibit 5, pursuant to Sections 8(a) and 8.2 of the Act. Respondent shall have a credit for all medical bills paid by it or its group insurance carrier.

Respondent shall pay Petitioner temporary total disability (TTD) benefits of $664.67/week for 8 5/7 weeks, commencing 09/01/2010 through 10/31/2010, as provided in Section 8(b) of the Act. Respondent shall have credit for TTD benefits paid, as noted above.

Respondent shall pay Petitioner the sum of $598.20/week for a period of 99.45 weeks, as provided in Section 8(e) of the Act, because the injuries sustained caused the 15% loss of use to both hands, and the 15% loss of use to the left arm.

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

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

03/05/2014
Date

MAY 15 2014

15IWCC0020

STATE OF ILLINOIS)
) SS
COUNTY OF JEFFERSON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

MARY K. TICER
Employee/Petitioner

v. Case # 11 WC 34958

ILLINOIS DEPT. OF CORRECTIONS –
BIG MUDDY RIVER CORRECTIONAL CENTER
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner, Mary Ticer, has worked with Respondent, the Big Muddy River Correctional Center, since November 16, 1992. Petitioner's job duties between 2005-2008 centered around work in Respondent's Adjustment Committee. Petitioner testified that while working for the Adjustment Committee, she performed a considerable amount of data entry at a rate of about 30-40% of her day. From 2008 until mid-2009, Petitioner served as a wing officer, which did not involve data entry. That job did require her to perform key turning activities, but she acknowledged that many of the locks were electronic. In mid-2009, Petitioner began to work in the Placement Office, where she testified that 80% of her day involved data entry. After working in the Placement Office for several months, Petitioner's hands and left elbow hurt severely enough that she sought medical treatment for the problems.

In July 2010, Petitioner was diagnosed by orthopedic surgeon Dr. James Chow with left elbow ulnar nerve problems as well as bilateral carpal tunnel syndrome (CTS). (Petitioner's Exhibit (PX) 2). Petitioner testified that her symptoms began and progressed over a period of a few years before seeking treatment for those problems in the summer of 2010, when said symptoms became so severe that she sought medical treatment. (See *supra*). Petitioner reported her problems to Respondent on June 7, 2010. In her incident report, Petitioner documented that her symptoms began sometime in March 2008. (RX 2; RX 3). Petitioner testified that she notified Respondent of all of her injuries again in July 2010. Petitioner decided to seek treatment elsewhere, and began a course of medical care with Dr. Steven Young, another orthopedic surgeon. Dr. Young performed a left ulnar nerve transposition and left carpal tunnel release on August 28, 2010. He followed-up with the right carpal tunnel release on September 17, 2010. Petitioner was released to return to work on October 31, 2010. Petitioner went through a course of post-operative physical therapy until she was released from care by Dr. Young on December 20, 2010. (PX 1). At that time Petitioner returned to her pre-surgery job with Respondent.

Dr. Young testified that, based on Petitioner's history and given his experience as an orthopedic surgeon, Petitioner's job duties contributed to her symptoms of bilateral CTS and left cubital tunnel syndrome. He also testified that Petitioner's treatment and surgeries were reasonable and necessary to treat Petitioner's conditions. (PX 4, pp. 9-10).

On March 25, 2013, Dr. Anthony Sudekum performed a medical records review at Respondent's request pursuant to Section 12 of the Illinois Workers' Compensation Act, 820 ILCS 305/1 *et seq*. (hereafter the "Act"). (RX 1, Dep. Exh. 2). The doctor did not believe that Petitioner's conditions were caused or aggravated by her job duties with Respondent. (RX 1, pp. 22-28; Dep. Exh. 2).

Petitioner testified that she still experiences numbness and tingling in her right hand. She also experiences pain while at work, as well as at night. She also experiences some hand swelling. Petitioner experiences pain in the scar areas from her surgery.

Most if not all of Petitioner's medical costs were paid by Respondent. (See PX 5). Petitioner claims to be entitled to temporary total disability (TTD) benefits from September 1, 2010 through October 31, 2010. Respondent is disputing Petitioner's entitlement to TTD benefits, but the parties stipulated that all TTD benefits were indeed paid by Respondent.

CONCLUSIONS OF LAW

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

Petitioner has worked for Respondent since 1992. Petitioner testified that she began to have symptoms of pain and discomfort in her hands and left elbow in 2008. Petitioner testified that in the three years prior to 2008, she had worked with the Adjustment Committee, where she explained that 30-40% of her job involved data entry. In 2008, Petitioner was moved within the facility to a new position that was far less hand intensive. During that period, she had a reduction of symptoms with her hands and elbow. In mid-2009, she again changed positions, this time to the Placement Office, where she described her job as involving 80% data entry. By mid-2010, Petitioner had enough pain and numbness in her hands and elbow that she felt she had to seek medical treatment. Her treating physician, Dr. Young, testified that Petitioner's job activities contributed or exacerbated her condition of left-sided ulnar nerve problems and bilateral CTS. Dr. Sudekum testified for Respondent and opined that Petitioner's job activities did not rise to his standard of hand intensity to warrant a causal connection to Petitioner's condition. Dr. Sudekum never examined Petitioner. The Arbitrator places more weight on the opinions of treating surgeon, Dr. Young, and hereby adopts Dr. Young's opinions. Based on the foregoing, the Arbitrator finds that Petitioner's bilateral CTS and left elbow injury arose out of and in the course of her employment by Respondent.

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

Petitioner notified Respondent of repetitive trauma injuries in June 2010. Her diagnoses of bilateral CTS and left cubital tunnel syndrome were given following a nerve conduction study on July 6, 2010. Petitioner testified that she again notified Respondent of her conditions in July 2010. The Arbitrator therefore finds that Petitioner provided timely notice of the accident to Respondent.

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

Petitioner worked a position with the Adjustment Committee from 2005 through 2008, where her job duties included hand-intensive date entry for 30-40% of every day. In 2008, Petitioner began to struggle with pain and numbing in her hands and left elbow. Following this job until approximately mid-2009, Petitioner worked in a different position as a wing officer, where there were far less hand-intensive activities. During this time, her symptoms decreased significantly. Following her tenure as a wing officer, Petitioner was transferred to the Placement Office. In this position, Petitioner testified that her job responsibilities consisted of 80% data entry. After performing this job for several months, Petitioner had so much pain and loss of function in her hands that she had to pursue treatment. Petitioner's treating physician, Dr. Young, opined that her job duties contributed to her condition. Dr. Sudekum, the physician who conducted a medical records review for Respondent, opined that Petitioner's job duties as he understood them could not cause or aggravate Petitioner's condition. The Arbitrator finds the opinions of Dr. Young more persuasive, and based on his opinions and the credible testimony of Petitioner, Petitioner's current condition of ill-being is causally related to the work related repetitive trauma injuries.

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?

All of the medical services that were provided to Petitioner were found to be reasonable and necessary by Petitioner's treating physician, Dr. Young. Having adopted the opinions of Dr. Young, the Arbitrator hereby awards Petitioner the medical expenses incurred as a result of the injuries at issue, as set forth in Petitioner's Exhibit 5. Respondent shall have a credit for all medical bills paid by it or through its group insurance carrier.

Issue (K): What temporary benefits are in dispute? (TTD)

Petitioner was taken off work by her treating physician from the time of her first surgery, August 28, 2010, through October 31, 2010. Petitioner is entitled to TTD benefits for the period of September 1, 2010 through October 31, 2010, and all TTD benefits have been paid by Respondent.

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

Petitioner has work related injuries to her left elbow and to her right and left hands. She proceeded with an ulnar nerve transposition on her left elbow and with bilateral carpal tunnel releases. She still experiences some pain, numbness and tingling. As a result, the Arbitrator finds that Petitioner is permanently partially disabled to the extent of 15% loss of use to each hand, and the 15% loss of use to the left arm, pursuant to Section 8(e) of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Harold Mays,

Petitioner,

15IWCC0021

vs.

NO: 10 WC 18126
12 WC 17345
12 WC 17346

Material Science Corporation,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent and Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, temporary disability, average weekly wage and penalties and fees and being advised of the facts and law, reverses the Decision of the Arbitrator as stated below on the issue of causal connection. The Commission further remands this case to the Arbitrator for further proceedings for a determination of permanent disability, pursuant to *Thomas v. Industrial Commission*, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

The cases were consolidated for hearing and the Arbitrator filed three decisions on April 3, 2014. Petitioner was fifty-one years old on the first date of accident, December 21, 2009. He was a long-term employee with experience in various job titles. While working as a Slitter Helper on December 21, 2009, Petitioner was struck with a piece of machinery and fell onto his right wrist. He underwent right wrist surgery on May 3, 2010 and November 19, 2010 consisting of an arthroscopy and debridement, open carpal tunnel release, radial tunnel release, proximal row carpectomy and posterior interosseous neurectomy.

Respondent underwent economic restructuring in 2010, and while Petitioner was on temporary total disability his job was eliminated. Having substantial seniority with Respondent,

Petitioner was allowed to choose a new position to which he could return when released by his doctor. Petitioner chose Quality Assurance, a higher paying position and one that was already familiar to him though he required some retraining. Petitioner's wrist surgeon, Dr. Atluri, released him to return to full duty work. On his first day, May 23, 2011, he reported experiencing pain and popping in his right wrist. He immediately returned to Dr. Atluri and was issued restrictions leading to another period of temporary total disability through January 15, 2012.

Petitioner sought a second opinion with a new surgeon, Dr. Wiedrich. Dr. Wiedrich performed a right radial styloidectomy on August 19, 2011. By November of 2011, Dr. Wiedrich placed Petitioner at maximum medical improvement and recommended a functional capacity evaluation. The evaluation was conducted on November 3, 2011. Athletico noted variable effort on the part of Petitioner, but that he was able to perform the full job demands required by the Quality Assurance position. Petitioner indicated that he had concerns with respect to a specific job task, "heat taping." The evaluators were unable to replicate the activity in the clinical setting. Dr. Wiedrich issued restrictions on November 9, 2011 stating no lifting over twenty pounds and the avoidance of heat taping.

Dr. Papierski examined Petitioner at the request of Respondent on December 27, 2011. Dr. Papierski found that Petitioner was still complaining of occasional sharp shooting pains in his right wrist. Dr. Papierski reviewed the functional capacity evaluation report and the position description for the Quality Assurance position. Dr. Papierski opined that although Petitioner may have ongoing symptoms, there was no medical reason to preclude Petitioner from returning to full duty work.

Petitioner was advised to return to work on January 16, 2012. Petitioner called in sick, due to having not slept the night before. On January 17, 2012 Petitioner reported to work and presented Dr. Wiedrich's November 9, 2011 restrictions. Petitioner was instructed to begin education and retraining for the Quality Assurance position and to obtain a recent work restrictions note. At the request of Petitioner Dr. Wiedrich issued new restrictions, again preventing Petitioner from heat taping. Petitioner advised his employer that he could not do the Quality Assurance job because he could not do the heat taping, and he was placed on short term disability. Petitioner's attorney filed a §19(b) and 8(a) petition and petition for penalties and fees under §19(l), §19(k) and §16. Respondent contended that Dr. Papierski found no medical reason why Petitioner could not perform the Quality Assurance job on a full duty basis. Petitioner returned to work and resumed observation and retraining on February 7, 2012. The following day, Petitioner called in sick again because he had not been able to sleep. On February 9, 2012, Petitioner completed observation and safety training. Petitioner was next scheduled to work regular duty on February 13, 2012.

On February 13, 2012, Petitioner clocked in at 7:00 a.m. and began working on the Quality Assurance line. Within a few hours, Petitioner stopped working and reported that he felt a pop in his right wrist while heat taping. Petitioner reported this occurrence as a new accident and was seen at Alexian Brothers Medical center that morning. Petitioner was diagnosed with a

sprain or strain of the right wrist and thumb. X-rays showed no change from his previous studies on December 1, 2010. Petitioner was issued restrictions against using his right hand and directing him to wear a splint. Petitioner remained off of work and Respondent paid temporary total disability benefits from February 13, 2010 through March 12, 2012. Petitioner saw Dr. Wiedrich on February 20, 2012 and gave a history of a new injury where his wrist popped as he attempted heat taping. Dr. Wiedrich issued restrictions against using the right hand and he expected that Petitioner would be at maximum medical improvement in one week.

Dr. Papierski examined Petitioner again on February 27, 2012. Dr. Papierski believed that Petitioner sustained a temporary strain or sprain of the right wrist as a result of the new occurrence but no new structural damage. He recommended that Petitioner return to normal duties within three to four weeks. On March 5, 2012, Dr. Wiedrich noted that he would like to see a video of the heat taping activity to determine whether it was something Petitioner could or could not perform. When Dr. Wiedrich was deposed, he admitted that he did not have any objective knowledge of what heat taping physically entailed and he never saw a video; he relied on Petitioner's statements. Petitioner reported to him that heat taping caused pain and popping in his right wrist. Dr. Wiedrich noted that the functional capacity report also indicated that Petitioner was concerned about applying heat tape. Dr. Wiedrich testified that most likely the particular wrist movement could cause a sudden shift of the capitate bone of the palm on the radius, causing a popping sensation that is uncomfortable for Petitioner.

Petitioner returned to work at 7:00 a.m. on March 13, 2012 and immediately claimed to have reinjured his right wrist as soon as he began working. Petitioner's supervisor, Mr. Warrick, testified at hearing. He watched Petitioner closely on the morning of March 13, 2012, and saw no sign of injury. Furthermore, Mr. Warrick testified that Petitioner complained that his hand was tingling and swelling even before he performed any work activities. Respondent disputed Petitioner's claim of a work-related accident on March 13, 2012 on a factual basis. Petitioner saw Dr. Wiedrich on March 19, 2012. Dr. Wiedrich did not believe that Petitioner sustained any additional injury to his wrist on March 13, 2012 and he recommended Petitioner return to work within the guidelines determined by the functional capacity evaluation and that he should avoid heat taping. Petitioner did not return to Dr. Wiedrich after March 19, 2012.

On May 1, 2012, Dr. Papierski issued an addendum report specifically addressing the heat taping activity. He reviewed the job analysis and the job video. The evidence shows that heat taping involves peeling a pre-cut piece of tape from its backing and placing it on an item in order to later measure the temperature. Dr. Papierski opined that the activity did not pose a risk of injury to Petitioner's right wrist. He believed that Petitioner could experience symptoms, as with any right hand activity, but he did not believe that there was any medical reason to restrict Petitioner from heat taping. Furthermore, Mr. Warrick testified that although heat taping was a necessary, if infrequent, function of the Quality Assurance job it required only minimal force and dexterity. Heat tape could be applied with the left hand and imprecise or askew application has no effect on readability.

Following pre-trial discussions, Petitioner agreed to attempt to return to work and apply heat tape with his left hand as a modification in order to perform the Quality Assurance job. Petitioner called in sick on his first and second scheduled days, May 14, 2012 and May 15, 2012. On May 16, 2012, Petitioner reported to work but left within a few hours, claiming to be ill. Petitioner also reported illness on May 17, 2012 and May 18, 2012. He then went on short term disability from May 22, 2012 through May 30, 2012. On June 4, 2012 Petitioner attempted to work for two hours, and then told his supervisor that he could not work due to the heat taping and "T-Bends" tasks. Petitioner was seen at Alexian Brothers on June 6, 2012. He requested to go back on temporary total disability, which was denied by Respondent.

Petitioner purportedly underwent a self-directed job search between July 21, 2012 and May 11, 2013. He began working for a pool company and cleaned swimming pools from May 12, 2013 through September 7, 2013. Petitioner testified that after the seasonal work ended he could not seek a new job because he needed to care for his grandchildren at home. He testified that he intends to return to the workforce when he is no longer needed to care for his grandchildren.

The Arbitrator found that Petitioner proved he was not able to fully perform the Quality Assurance job as a result of the work accidents. The Arbitrator found that the second and third alleged accidents on February 12, 2012 and March 13, 2012 effectively showed that Petitioner was unable to perform the heat taping task and therefore could not fulfill the Quality Assurance position. We do not agree. We find that the record shows Petitioner's refusal to return to employment despite repeated requests and all reasonable accommodations on the part of Respondent. We find that Petitioner failed to prove that he cannot in good faith perform the Quality Assurance position. It is undisputed that the physical demands of the job fall within Petitioner's functional capacity other than the additional restriction against heat taping that was imposed as a direct response to Petitioner's statements. No doctor has opined that heat taping could actually injure Petitioner's right wrist, even if it could reasonably cause a popping sensation and discomfort. The job video does not appear to show any strenuous activity on the part of the Quality Assurance worker. It is undisputed that heat taping activity is a non-repetitive activity; it is performed no more than a few times per day. The job video showed the activities of peeling tape from the paper backing and applying the tape to the item; each activity is completed in a matter of seconds. We acknowledge Petitioner's testimony that the video does not show thicker, tackier pieces of tape that are sometimes used. He disputed the video as misleading because thicker tapes are more difficult to remove from their backing and require the use of greater force. However, Petitioner agreed that these thicker tapes are rarely used. Based on our review of all of the evidence, we conclude that the medical necessity of the restriction against heat taping is not supported by the preponderance of the evidence and that Petitioner failed to prove he is unable to fulfill the requirements of the Quality Assurance position.

Furthermore, we find that Petitioner failed to act in good faith. Although Petitioner returned to work briefly on March 13, 2012, the record shows that Petitioner made only a pretense of performing his job duties. He arrived at work claiming his wrist was already hurting,

and then immediately claimed a new injury. Petitioner resisted every subsequent direction to return to work by either calling in sick or refusing to perform his job. There is no evidence that Petitioner made a good faith effort to attempt heat taping with his uninjured left hand, he merely testified that he could not do it.

Petitioner was seen one final time by Dr. Wiedrich on March 19, 2012. Dr. Wiedrich found Petitioner to be at maximum medical improvement and released him from care. Dr. Wiedrich indicated that he expected Petitioner would return to him every time he was sent back to work, and Dr. Wiedrich testified that he was not willing to see Petitioner again and again for the same issue. We find that Petitioner is not entitled to any temporary total disability benefits or compensation for medical expenses after March 19, 2012. We agree with the Arbitrator that Petitioner's right wrist stabilized as of his last visit to Dr. Wiedrich on March 19, 2012

We find that Petitioner effectively abandoned his employment by Respondent on June 4, 2012. Furthermore, Petitioner subsequently obtained employment as a pool cleaner, using a sixteen foot long retractable aluminum or fiberglass skimmer to lift and remove debris from swimming pools for several months during the summer of 2013. We are not persuaded by Petitioner's testimony that using pool cleaning equipment is not a wrist-intensive activity and did not cause him to experience any symptoms. We find his testimony self-serving and lacking believability. Based on all of the evidence and our conclusion that Petitioner was not precluded from performing the Quality Assurance position for Respondent as a result of the December 21, 2009 accident, we do not find that Petitioner is entitled to vocational rehabilitation, maintenance or any temporary partial disability benefits.

We agree with the Arbitrator's finding with respect to Petitioner's entitlement to a higher average weekly wage based upon the higher salary he earned in Quality Assurance. It is not disputed that Petitioner's wages increased with the new job designation and that by February 13, 2012 and March 13, 2012 Petitioner's average weekly wage was $1,000.03. Although Petitioner never returned to work for an extended period of time after May 23, 2011, we find that under the Act Petitioner is entitled to the average weekly wage of $1,000.03 with respect to the February 13, 2012 and March 13, 2012 accidents. We remand this case to the Arbitrator for a determination of permanent partial disability.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $535.65 per week for a period of 91 4/7 weeks, commencing May 3, 2010 through May 22, 2011, May 25, 2011 through January 15, 2012, and January 18, 2012 through February 6, 2012, as provided in §8(b) of the Act, that being the period of temporary total disability for work with respect to 10 WC 18126, with Respondent receiving credit for the $47,519.89 in benefits paid prior to hearing.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $666.69 per week for a period of 4 1/7 weeks, commencing February 13, 2012 through March 12, 2012, as provided in §8(b) of the Act, that being the period of temporary

total disability for work with respect to 12 WC 17345, with Respondent receiving credit for $2,142.60 in benefits paid prior to hearing.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $666.69 per week for a period of 6/7 weeks, commencing March 14, 2012 through March 19, 2012, as provided in §8(b) of the Act, that being the period of temporary total disability for work with respect to 12 WC 17346.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the outstanding balance of $127.00 (Dr. Wiedrich, March 19, 2012), as provided in §8(a) and §8.2 of the Act with respect to 12 WC 17345, and that Respondent shall have credit for all previously made payments of medical expenses made to or on behalf of the Petitioner for reasonable and necessary treatment related to the work-related injury of December 21, 2009.

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

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have a credit of $173,203.87 pursuant to §8(j).

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

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: JAN 12 2015
RWW/plv
o-11/12/14
46

Ruth W. White

Charles J. DeVriendt

Daniel R. Donohoo

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

15IWCC0021

MAYS, HAROLD
Employee/Petitioner

Case# **10WC018126**

12WC017345
12WC017346

MATERIAL SCIENCE CORPORATION
Employer/Respondent

On 4/3/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.06% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0009 ANESI OZMON RODIN NOVAK KOHEN
JOHN POPELKA
161 N CLARK ST 21ST FL
CHICAGO, IL 60601

0766 HENNESSY & ROACH PC
EDWARD HENNESSY
140 S DEARBORN 7TH FL
CHICAGO, IL 60603

15IWCC0021

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)

Harold Mays
Employee/Petitioner

v.

Material Science Corporation
Employer/Respondent

Case # **10 WC 18126**

Consolidated cases: **12 WC 17345**
12 WC 17346

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Molly Mason**, Arbitrator of the Commission, in the city of **Chicago**, on **01/21/14 and 01/22/14**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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 **Vocational Rehabilitation**

FINDINGS

On **12/21/09**, 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. 15IWCC0021

In the year preceding the injury, Petitioner earned $**41,780.96**; the average weekly wage was $**803.48**.

On the date of accident, Petitioner was **51** years of age, ***married*** with **0** dependent children.

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

Respondent shall be given a credit of $**47,519.89** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $ **47,519.89**.

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

ORDER

Respondent shall pay Petitioner maintenance benefits of $0/week for 0 weeks commencing n/a through n/a, as provided in Section 8(a) of the Act. See decision in 12 WC 17346 for the Arbitrator's maintenance award and findings as to Petitioner's claim for vocational rehabilitation.

Respondent shall pay Petitioner temporary partial disability benefits of $0/week for 0 weeks commencing n/a through n/a, as provided in Section 8(a) of the Act. See decision in 12 WC 17346 for the Arbitrator's TPD award.

In the instant case, 10 WC 18126, Respondent shall pay Petitioner temporary total disability benefits of $535.65/week for 91 4/7 weeks commencing 05/3/10 – 05/22/11; 5/25/11 – 1/15/12; 01/18/12 – 02/06/12, as provided in Section 8(b) of the Act, with Respondent receiving credit for the $47,519.80 in benefits it paid prior to hearing. Arb Exh 1.

Respondent shall pay Petitioner temporary total disability benefits that have accrued from 12/21/09 through 01/22/14, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall be given a credit of $47,159.89 for temporary total disability benefits that have been paid. Arb Exh 1.

For the reasons set forth in the attached decision, the Arbitrator declines to award penalties and fees, as requested by Petitioner.

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

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

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

Molly C Mason
Signature of Arbitrator

3/31/14
Date

APR 3 - 2014

Harold Keith Mays v. Material Science Corporation
10 WC 18126, 12 WC 17345-6 (consolidated)

15IWCC0021

Arbitrator's Findings of Fact Relative to All Cases

Petitioner was 55 years old as of the January 21, 2014 hearing. He goes by the name "Keith." He testified he is right-handed. He is 6 feet, 3 inches tall. As of the hearing, he weighed 280 pounds. He testified he has put on about 30 pounds since December 2009. T. 25-26.

In 10 WC 18126, the parties agree Petitioner was injured at work on December 21, 2009. Arb Exh 1. Petitioner testified he worked for Respondent for 31 years before this accident. T. 22. He held a variety of jobs during that period. He was a member of the steelworkers' union throughout his tenure. T. 26. His job titles included quality control worker, skid and box builder, paint room worker, Line 4 pay-off, Line 3 crew chief, slitter assistant, slitter crew chief and embosser helper. T. 26-28.

Petitioner testified he worked as a slitter helper as of December 21, 2009. As a slitter helper, he did packaging and operated a Jeep and forklift. He used a variety of tools, including banders, razor blades and knives. The bander was used to apply bands around large coils of steel or aluminum. These coils weighed between 20 and 45,000 pounds. T. 23-24. He routinely lifted skids that weighed around 50 or 60 pounds. He typically moved these skids by hand "because it was quicker." T. 23. If a skid weighed more than 60 pounds, he used the forklift to move it. He spent about 60 to 70 percent of each workday on his feet and about 30% operating the Jeep. T. 25.

Petitioner testified that, on December 21, 2009, one of his co-workers "backed up [a forklift] really quick," striking a "tilter" in the process. Petitioner described the tilter as a machine that is 8 feet tall and weighs thousands of pounds. The tilter sat on the floor between two large safety plates that were bolted to the ground. When the co-worker struck the tilter, one of the plates broke loose and "swung out," catching the back of Petitioner's feet and swinging Petitioner backward through the air. Petitioner testified his back and right elbow struck the tilter as he swung backward. As he started falling downward, he tried to grab a bar with his right hand but his hand "slipped off." He landed on concrete, striking his right elbow and the right side of his wrist. T. 32.

Petitioner testified he felt pain in his back, right wrist and right arm immediately after the accident. He noticed that his right elbow was bleeding. T. 33.

Petitioner denied injuring his low back prior to December 21, 2009. He had injured his right wrist and hand before that date but those injuries consisted only of cuts. T. 33.

Petitioner testified he saw Dr. McAndrew at Alexian Brothers Corporate Health Services [hereafter "Corporate Health"] the same day he was injured. Respondent sent him to this

facility. T. 34-35. He underwent drug and alcohol testing there. The test results were negative. Dr. McAndrew examined him and sent him to another facility for X-rays. T. 34-35.

The Corporate Health records of December 21, 2009 set forth a consistent account of the work accident. The records reflect that Petitioner primarily complained of his right wrist and hand but also complained of back pain. Petitioner indicated he struck the back of his right wrist. He complained of "throbbing and tingling" in his right hand. PX 1, p. 3. On right wrist examination, Dr. McAndrew noted pain over the snuffbox area, mild swelling and a full range of motion. He also noted the possibility of a foreign body in the thenar area. Right elbow and right wrist X-rays showed no evidence of fracture or dislocation. Right hand X-rays showed no evidence of fracture or dislocation and no definite evidence of a radio-opaque foreign body. PX 1, pp. 10-12. Dr. McAndrew diagnosed contusions of the right wrist, right elbow and back. He prescribed Ibuprofen and ice applications. He released Petitioner to light duty with no lifting over 10 pounds with the right hand, limited gripping/grasping/pinching with the right hand and overall lifting/pushing/pulling limited to 20 pounds. PX 1, p. 6.

Petitioner testified he began performing light duty after December 21, 2009. He wore a splint constantly and "went to work in pain." His wrist "kept getting worse and worse." T. 36.

Petitioner returned to Corporate Health on January 5, 2010 and again saw Dr. McAndrew. T. 36. The doctor noted that Petitioner was still experiencing back and right elbow soreness but primarily complained of right wrist pain and numbness in his fingers.

Dr. McAndrew re-examined Petitioner and prescribed new right wrist X-rays with navicular views. He refilled the Ibuprofen and provided Petitioner with a wrist splint. He released Petitioner to light duty with lifting/pushing/pulling with the right arm limited to 10 to 20 pounds, no climbing, limited gripping/grasping with the right hand and no pounding or hammering with the right hand. He stressed the importance of adhering to the restrictions and instructed Petitioner to follow up on January 13, 2010. He indicated he "left VM for T. Grilli re: importance of follow RTW." PX 1, p. 18.

The new right wrist X-rays, performed on January 5, 2010, showed "mild degenerative type subchondral cysts" but no definite evidence of acute fracture or dislocation. The radiologist indicated that an MRI should be given consideration "given the history of persistent pain." PX 1, p. 19.

Petitioner returned to Corporate Health on January 13, 2010, as directed, and again saw Dr. McAndrew. The doctor noted that Petitioner was wearing his wrist splint and that he complained of wrist pain that worsened with use and episodes of numbness in the first, second and third fingers of his right hand.

On right wrist examination, Dr. McAndrew noted pain over the distal radius, no swelling and a full range of motion. He described Tinel's and Phalen's testing as negative. PX 1, p. 23.

Dr. McAndrew again diagnosed a right wrist contusion. He described Petitioner's back and elbow problems as "resolved." He recommended that Petitioner see a hand specialist. He instructed Petitioner to continue taking the Ibuprofen and wearing the splint. He released Petitioner to light duty with right hand lifting/carrying limited to 15 pounds and limited use of the right hand and arm. PX 1, pp. 25-26.

Petitioner saw Dr. Atluri, a hand surgeon, on January 20, 2010. Dr. Atluri sent a report to Teresa Grilli of Respondent the same day. The report sets forth a consistent account of the December 21, 2009 work accident. Dr. Atluri noted that Petitioner's back and elbow symptoms had resolved but that he was still experiencing pain in his right hand and wrist, especially at the base of the thumb, along with occasional tingling shooting into the dorsal hand and thumb. He also noted that Petitioner denied any prior right hand problems.

On right wrist examination, Dr. Atluri noted limited range of motion, swelling with mild tenderness over the scapholunate interval, tenderness at the anatomic snuff box and first dorsal extensor compartment, maximum tenderness at the thumb CMC joint, tenderness at the distal pole of the scaphoid, negative Finkelstein's testing, positive thumb CMC grind, pain but no clunking with Watson's testing and "nearly full digital motion but [inability] to make a tight fist due to pain." PX 1, p. 34.

Dr. Atluri obtained right wrist X-rays, including scaphoid views. He indicated the films showed no obvious fractures or carpal mal-alignment.

Dr. Atluri's impression was "right wrist derangement." He suspected a ligamentous injury and could not rule out an occult scaphoid fracture. He prescribed a right wrist MRI and converted Petitioner to a forearm-based thumb spica splint. PX 1, pp. 31-32. He instructed Petitioner to wear this splint at home and work. He released Petitioner to light duty with lifting/carrying/pushing/pulling limited to 5 pounds, limited gripping/grasping with the right hand and splint usage. He instructed Petitioner to return after the MRI. PX 1, pp. 33, 35.

The right wrist MRI, performed without contrast on January 27, 2010, showed a "small joint effusion dorsal to the distal scaphoid compatible with mild synovitis." The radiologist indicated that the triangular fibrocartilage and scapholunate ligament appeared to be intact. He also indicated that the MRI had to be performed on a 0.3 T MRI "due to claustrophobia." PX 1, pp. 147-148.

Petitioner returned to Dr. Atluri on February 3, 2010. The doctor described the MRI as a "poor quality study." He described the MRI as showing no fractures or evidence of Kienbock's disease. He indicated the MRI was "otherwise non-diagnostic." He also indicated he was "still concerned about a possible ligament injury" but recommended another six weeks of conservative care. He stated he would consider performing an arthroscopy if Petitioner remained symptomatic at that point. He prescribed occupational therapy and continued the previous work restrictions. PX 1, pp. 36-39.

At the next visit, on March 17, 2010, Dr. Atluri noted that Petitioner continued to complain of right wrist pain and also complained of "increased numbness in the thumb, index and middle fingers."

On examination, Dr. Atluri noted tenderness at the thumb CMC joint, positive thumb CMC grind with some crepitus and positive digital compression testing over the carpal tunnel. He prescribed an EMG and continued the previous work restrictions. T. 40. PX 1, pp. 40-43

Dr. Barbara Heller, a physiatrist, performed EMG/NCV testing of Petitioner at Occspecialists on April 1, 2010. Dr. Heller interpreted the EMG/NCV as providing "electrodiagnostic evidence of a moderate sensory and motor primarily demyelinating carpal tunnel syndrome or median nerve entrapment neuropathy at the right wrist. PX 2, p. 6.

Petitioner returned to Dr. Atluri on April 7, 2010 and complained of increased numbness and tingling in his right hand. The doctor reviewed the EMG/NCV results. On examination, he noted a positive Tinel's over the carpal tunnel and over the dorsal radial sensory nerve with tenderness along the dorsal radial aspect of the wrist and distal forearm. He also noted a positive Watson, although "no significant tenderness over the dorsal wrist."

Dr. Atluri's impression was: carpal tunnel syndrome, Wartenberg syndrome and right wrist derangement. He indicated he still suspected a ligamentous injury. He noted that Petitioner had undergone four months of conservative care without resolution of his symptoms. He discussed various surgical options, including a carpal tunnel release and dorsal radial sensory nerve decompression. He noted that Petitioner agreed to undergo surgery. He continued the previous work restrictions. PX 1, pp. 44-48.

On May 3, 2010, Dr. Atluri operated on Petitioner's right wrist at Alexian Brothers Medical Center. T. 41. The surgery consisted of a right wrist arthroscopy with debridement of a TFCC tear, an open carpal tunnel release, a dorsal radial sensory nerve neurolysis and an open radial tunnel release. In his operative report, Dr. Atluri noted that the scapholunate ligament was "bulging" but not torn and that the TFCC "had a radial-sided tear with irregular flaps." He also noted that the dorsal radial sensory nerve was "healthy in appearance distally" but "demyelinated and flattened along the edge of the brachioradialis tendon." Proximal dissection revealed that the nerve was dymyelinated "even beyond the brachioradialis tendon." PX 3, pp. 42-44. PX 3. Following the surgery, Dr. Atluri instructed Petitioner to stay off work and avoid using his right hand. PX 3, p. 12.

Petitioner testified he began losing time from work as of the May 3, 2010 surgery. He initially received temporary total disability benefits. T. 41.

Petitioner testified he underwent occupational therapy at Alexian Occupational Clinic from May 10, 2010 through August 19, 2010. T. 41. He continued seeing Dr. Atluri during this time. T. 42.

On May 26, 2010, Dr. Atluri noted that Petitioner described his finger symptoms as improved but still complained of pain in the forearm and hand. On examination, the doctor noted that Petitioner could not make a fist. He also noted swelling and diffuse tenderness throughout the hand and forearm. He recommended that Petitioner continue therapy. He released Petitioner to work with no use of the right hand or arm. PX 1, pp. 52-56.

Petitioner testified he obtained some benefit from the surgery. Petitioner also testified that Respondent was unable to accommodate Dr. Atluri's restriction of no use of the right hand or arm. T. 42-43.

On June 23, 2010, Dr. Atluri noted that Petitioner's forearm pain had diminished but that he was still experiencing pain in the wrist, "particularly at the radial aspect of the wrist along with some tingling at the dorsal thumb." He prescribed additional therapy and continued the previous work restriction. PX 1, pp. 59.

On August 4, 2010, Dr. Atluri noted that Petitioner had plateaued in therapy and reported being unable to progress past 3 pounds due to wrist pain.

On examination, the doctor noted tenderness at the dorsal wrist near the scapholunate interval, a positive TFC grind with some crepitus, mild tenderness over the first extensor compartment, a negative Finkelstein's test, pain with wrist motion past 30 degrees of extension and 55 degrees of flexion, weak grip strength and pain with forceful gripping.

Dr. Atluri advised Petitioner that only a total wrist arthrodesis would completely eliminate Petitioner's pain. He viewed a limited arthrodesis as a better option, function-wise. He also viewed a proximal row carpectomy as a reasonable option. He indicated Petitioner might require permanent restrictions postoperatively. T. 44. He discontinued therapy (T. 43), continued the previous restriction and noted that Petitioner planned to return in two weeks. PX 1, pp. 62-65.

In his note of August 18, 2010, Dr. Atluri indicated that Petitioner opted for a proximal row carpectomy. He also indicated he warned Petitioner that this surgery would not eliminate all of the symptoms. He continued the previous restriction. PX 1, pp. 66-70.

Petitioner testified he decided to undergo surgery as of August 18, 2010 but told Dr. Atluri he wanted to obtain a second opinion concerning his surgical options. T. 44-45. He called the workers' compensation carrier and asked if there was a doctor they could recommend. They recommended he see Dr. Papierski. T. 44.

On September 29, 2010, Petitioner returned to Dr. Atluri. Petitioner reported that he was still awaiting surgical authorization and that he was scheduled to see Dr. Papierski for an IME. On examination, Dr. Atluri noted pain with range of motion and "positive Watson's tenderness radially and dorsally." He continued the previous restriction. PX 1, pp. 72-75.

At Respondent's request, Petitioner saw Dr. Papierski for a Section 12 examination on September 30, 2010. Dr. Papierski is a board certified orthopedic surgeon with added qualification in hand surgery. He is also a certified medical examiner. RX 3 at 4-5. Papierski Dep Exh 1.

Dr. Papierski's report concerning his September 30, 2010 examination is not in evidence. At his April 12, 2013 deposition, Dr. Papierski testified he reviewed Dr. Atluri's note of August 18, 2010 in connection with that examination. He viewed Dr. Atluri's various surgical recommendations as reasonable. His own recommendation "included trying to isolate where pain in [Petitioner's] wrist might be coming from," via injecting local anesthetic into various areas of the wrist "to see which areas of the wrist would be getting relief of pain." He also felt that Petitioner's condition "would probably merit additional treatment." He believed consideration could be given to an extensor tendon compartment release, an arthroscopic resection of the distal ulna or proximal hamate or a radioscapholunate arthrodesis, "another type of limited fusion." RX 3 at 7-8.

On October 20, 2010, Petitioner discussed Dr. Papierski's findings and recommendations with Dr. Atluri. Dr. Atluri noted that Petitioner indicated he was interested in surgery rather than additional conservative care. Petitioner again opted to undergo a proximal row carpectomy. Dr. Atluri continued the previous restriction. PX 1, pp. 76-80.

On November 19, 2010, Dr. Atluri performed a right wrist proximal row carpectomy and a right wrist posterior interosseous neurectomy at Alexian Brothers Medical Center. PX 3. Post-operative X-rays revealed "good carpal alignment with post-surgical changes." They also revealed that the capitates was "well seated in the lunate fossa." PX 3, pp. 80-81. Following the surgery, Dr. Atluri instructed Petitioner to stay off work and avoid using his right hand and arm. PX 3, p. 67.

Petitioner testified that, at some point after the November 19, 2010 surgery, he noticed he was still experiencing pain in his right thumb and wrist. T. 47.

On November 24, 2010, Petitioner began a course of therapy at Alexian Occupational Clinic. On that date, the evaluating therapist noted that Petitioner's right hand and wrist "presented with severe pitting edema." The therapist utilized massage techniques in an effort to reduce this edema. PX 1, p. 139.

Petitioner testified that, on November 30, 2010, he was performing therapy when he noticed and heard a popping noise in his right wrist and thumb. He had never experienced this before. T. 48. Within half an hour of hearing the noise, he began experiencing swelling. T. 48-49. The therapist applied ice to the affected area. T. 49.

The following day, December 1, 2010, Dr. Atluri noted that Petitioner complained of a "pop" while exercising. The doctor obtained right wrist X-rays. He described the X-rays as looking okay. He instructed Petitioner to continue wearing the splint and attending therapy.

On December 29, 2010, Petitioner returned to Dr. Atluri. On examination, Dr. Atluri noted significantly less swelling but very reduced grip strength. He indicated Petitioner could flex his fingers to mid-palm but could not make a fist. He instructed Petitioner to wean off the splint and continue therapy. He continued the previous restriction. PX 1, pp. 84-87.

On January 26, 2011, Dr. Atluri injected cortisone into Petitioner's right thumb CMC joint. He directed Petitioner to wear a thumb CMC joint splint at night and continue therapy. He imposed new restrictions of no lifting/carrying/pushing/pulling, limited grasping/pinching and splint usage. PX 1, pp. 88-93.

At the next visit, on February 23, 2011, Petitioner reported no improvement secondary to the injection. He continued to complain of pain at the base of his thumb. Dr. Atluri recommended that Petitioner continue therapy for another month and then potentially transition to work conditioning. He continued the previous restrictions. PX 1, pp. 94-99.

On April 5, 2011, Dr. Atluri recommended that Petitioner transition to work conditioning. PX 1.

On April 7, 2011, Petitioner underwent a work conditioning evaluation at AthletiCo. The evaluating therapist recorded a history of the December 21, 2009 injury and subsequent care. The therapist also noted that Petitioner was subject to work restrictions, that no light duty was available and that Petitioner was "looking to return to work with quality assurance duties." Petitioner reported a pain rating of 1-2/10 at rest that increased to 7-8/10 "during forceful gripping and lifting activities." On examination, the therapist noted grip strength of 60 pounds on the right (versus 100 on the left), three-point pinch strength of 16 pounds on the right (versus 26 on the left) and lateral pinch strength of 20 pounds on the right (versus 29 on the left). PX 5.

Petitioner returned to Dr. Atluri on May 3, 2011. The doctor noted that Petitioner was making good progress in work conditioning. He indicated he had been provided with a written description of a job that required lifting up to 25 pounds. He released Petitioner to this job on a part-time basis for the next two weeks, indicating that Petitioner should continue work conditioning while performing the new job four hours per day. He indicated Petitioner could resume full duty after undergoing work conditioning for two weeks. PX 1, pp. 101.

Petitioner testified that work conditioning was beneficial in terms of increasing his overall activity level but it did not help his wrist or thumb. He continued experiencing swelling and pain. T. 53-54. A work conditioning note dated May 11, 2011 reflects Petitioner continued to complain of thumb pain and planned to see another surgeon in about a month. The same note reflects Petitioner reported a "pop" in his shoulder while performing "lat pull-downs" and cancelled a session scheduled for the following day due to shoulder pain. PX 5, pp. 56-57.

On May 12, 2011, Marianne Cornacchione, a claim supervisor affiliated with CCMSI [hereafter "Cornacchione"], sent the following note to Petitioner's counsel via facsimile:

> "Mr. Mays has been returned to work full duty as of Monday 5/23/11. Please see attached and advise your client."

PX 6, p. 1. Attached to this note is a letter bearing the same date from Cornacchione to Petitioner's counsel referencing and attaching Dr. Atluri's note of May 3, 2011. PX 6, p. 3. In the letter, Cornacchione indicated she authorized the additional two weeks of work conditioning the doctor prescribed on May 3, 2011. She further indicated that, per Dr. Atluri, Petitioner would be capable of full duty once the two weeks had been completed, that she would continue paying temporary total disability benefits through May 22, 2011 and that Respondent had scheduled Petitioner to return to work on Monday, May 23, 2011. PX 6, p. 2.

A document in the AthletiCo records (PX 5) reflects that Petitioner attended work conditioning through May 12, 2011 and was subsequently discharged from work conditioning based on a case manager's report that he resumed full duty on May 16, 2011. PX 5, p. 59. Petitioner did not testify to resuming full duty on that date. He testified Dr. Atluri never released him to full duty. T. 54-55. He further testified he began performing a quality assurance job at Respondent on May 23, 2011. On direct examination, he testified he started this job after participating in a speaker phone conference call with Bob and Teresa Grilli of Respondent and some union officials. He testified he did not anticipate receiving this call. During the call, he was told that the Respondent plant where he had previously worked had closed and that he had to choose a job to perform "at the next plant." The callers presented him with ten or eleven jobs, including a quality assurance job, to choose from. Petitioner testified he asked the callers whether he could have a day or two to think about his choice but was told he had to make a decision on the spot. He chose the quality assurance job because it paid the most and because he had worked in quality assurance for Respondent many years earlier. T. 59.

Petitioner testified that, when he presented to the quality assurance job on May 23, 2011, he was told he "had to learn how to do the job in ten days." An individual named Alex Aguirre trained him. T. 59-60.

Petitioner testified that one of his duties in the quality assurance job was to apply "heat tape" to the bottom of a metal strip that moved along an elevated line. He was required to apply heat tape the first day he worked in quality assurance. T. 60-61. Petitioner described heat tape as a "four-inch sticky piece of tape" that reads the temperature of metal "once it goes into ovens." T. 61. The line along which the metal strip moved was about 4 to 4 ½ feet above ground level. Petitioner testified he had to "duck a couple of feet to get under the strip." The rate at which the strip moved along the line varied, depending on the job. Petitioner testified the strip could move as slowly as 100 feet per minute to 260-300 feet per minute. T. 61. Petitioner indicated he had to use his thumb and index finger in order to affix the heat tape

to the moving metal strip. He had to "really push down" on the heat tape in order to make sure it stuck to the metal strip. T. 63-64. Petitioner would position himself under the line with his right elbow at a 90 degree angle away from his body and his right thumb pointing up. When the moving metal strip got close to him, and was almost overhead, he would forcefully push the heat tape onto the bottom of the strip and then keep pushing as the strip continue moving. His right thumb would move backward in the process. T. 64.

Petitioner testified that, on his first attempt at applying heat tape on the morning of May 23, 2011, he felt his right wrist pop and experienced pain in his right wrist and thumb. T. 65. He moved out from underneath the line and tried to shake off his pain, "hoping it was nothing major." He then ran down to the finish coater in order to apply another piece of heat tape. When he applied this piece, his right wrist "really popped." Petitioner testified he immediately reported this to his foreman. The foreman told him to sit down for a few minutes. He sat down but "the swelling started almost immediately" and his pain increased. T. 66. He did not resume working that day. T. 66-67.

Petitioner testified he was off work from May 24, 2011 through January 6, 2012. He received temporary total disability benefits during this period. T. 67.

On May 26, 2011, Petitioner returned to Dr. Atluri. The doctor noted that Petitioner had started a new light duty job but was complaining of increased thumb pain secondary to a number of work activities. Petitioner reported that the new job position required him to "apply pressure with his thumb and perform some pinching maneuvers." On examination, Dr. Atluri noted tenderness at the thumb CMC joint and a little bit of intermittent clicking with CMC grind.

Dr. Atluri obtained new X-rays. He interpreted the films as showing mild arthrosis at the thumb CMC joint and post-surgical changes.

Dr. Atluri indicated "it does not appear as if [Petitioner] can perform his light duty work due to his thumb pain." He did not feel the thumb arthritis warranted additional surgery. He noted that Petitioner "does feel better in the splint but states he cannot perform his necessary work duties with the splint in place."

Dr. Atluri advised Petitioner to use the splint for symptom control. He noted Petitioner was seeing Dr. Wiedrich for a second opinion. He indicated he thought this was an "excellent idea." He recommended that Petitioner return to him after seeing Dr. Wiedrich. He released Petitioner to restricted duty with splint usage. PX 1, pp. 102-103. PX 6.

Petitioner testified that, on May 26, 2011, he asked Dr. Atluri who he should see for his thumb after Dr. Atluri told him he was not a thumb expert and "couldn't do anything for the thumb area." According to Petitioner, it was at this point in the conversation that Dr. Wiedrich's name came up. Dr. Atluri recommended he see Dr. Wiedrich. T. 69.

Petitioner first saw Dr. Wiedrich on July 13, 2011. Dr. Wiedrich is a fellowship-trained hand surgeon. He achieved board certification in plastic surgery in 1994 and added qualification in hand surgery the following year. PX 4 at 6. He has been an assistant professor at Northwestern University's medical school since 1992. Wiedrich Dep Exh 2.

Dr. Wiedrich's initial note of July 13, 2011 reflects that "no data" was available as to the identity of the referring physician.

Dr. Wiedrich's note sets forth a consistent history of the December 21, 2009 work accident and subsequent care. He indicated that Petitioner complained of right thumb pain, which prevented him from working, and difficulty with right wrist extension. On range of motion testing, he noted dorsal flexion/proximal flexion of 30/55 in the right wrist and 65/65 in the left wrist and radial deviation/ulnar deviation of 5/20 in the right wrist and 20/30 in the left wrist. On right wrist examination, he noted mild dorsal wrist swelling and well-healed incisions about the wrist and forearm. He also noted radial styloid tenderness and mild tenderness of the first CMC joint. He obtained Fluoro Scan images and interpreted them as showing "evidence of radial trapezoid abutment." He indicated Petitioner "would benefit from a radial styloidectomy." He described his "plan" as follows: "IME report." He completed a disability certificate releasing Petitioner to restricted duty with limited use of the right hand, specifically "no forceful lifting and radial deviation." He indicated Petitioner should be off work if these restrictions could not be met. Wiedrich Dep Exh 3, p. 7.

Dr. Wiedrich wrote to Cornacchione and the nurse case manager, Gloria Torres, R.N., the same day, enclosing his note, describing Petitioner's work restrictions and indicating he anticipated Petitioner would reach maximum medical improvement three months after a radial styloidectomy. Wiedrich Dep Exh 3, p. 8.

On August 19, 2011, Dr. Wiedrich operated on Petitioner's right wrist at Northwestern Memorial Hospital. The surgery consisted of a radial styloidectomy and a release of the first dorsal compartment. Wiedrich Dep Exh 3, pp. 10-11.

Petitioner testified he did not notice much improvement following the surgery. He "still had the pain." T. 70.

Petitioner followed up with Dr. Wiedrich three days postoperatively. The doctor described Petitioner's radial nerve function as good. He placed Petitioner in a short arm thumb spica splint and instructed him to start occupational therapy and return in ten days. He released Petitioner to work with no use of the right hand. Wiedrich Dep Exh 3, pp. 12-15. Petitioner testified Respondent did not accommodate this restriction. T. 70-71.

At the next visit, on September 1, 2011, Petitioner complained to Dr. Wiedrich of pain with radial/ulnar deviation. He indicated he was wearing the splint most of the time. The doctor prescribed therapy and continued the previous work restriction. Wiedrich Dep Exh 3, pp. 16-19.

Petitioner testified he participated in therapy at Athletico through November 3, 2011. The therapy did not help much. He continued to experience pain and swelling. He had to apply ice to his right hand after each therapy session. T. 71-72.

On October 4, 2011, Dr. Wiedrich noted that Petitioner was still complaining of wrist pain and reported "marginal improvement." T. 72. On right wrist examination, the doctor noted diffuse tenderness, no significant swelling, no crepitus and a positive Tinel sign down the length of the entire superficial radial nerve. He obtained X-rays, which showed evidence of the surgeries and no significant arthritis. He prescribed four more weeks of therapy, followed by a functional capacity evaluation. He continued the previous work restriction. Wiedrich Dep Exh 3, pp. 20-25.

Petitioner underwent a functional capacity evaluation at AthletiCo on November 3, 2011. In his report of that date, the evaluator described Petitioner as cooperative throughout the evaluation. He described Petitioner's effort as variable and noted "minor inconsistency to the reliability and accuracy of [Petitioner's] reports of pain and disability." He noted "maximum voluntary effort" with Jamar grip strength testing. Petitioner's grip strength was 60.67 pounds on the right versus 92 on the left. Petitioner successfully completed a pegboard manual dexterity test but exhibited signs of discomfort during this test. Based on both a DOT job description and a job description provided by Respondent, the evaluator found Petitioner capable of "returning to his pre-injury job demands as a quality assurance analyst." He noted, however, that Petitioner described heat tape application as his "biggest concern" with the target job position. He indicated he was "unable to test specific work tasks related to application of heat tape" but that Petitioner was able to participate in "workflow simulation" twice. He indicated that, during this simulation, Petitioner reported right wrist fatigue and "demonstrated signs of discomfort." Near the end of his report, he stated that Petitioner might benefit from a pain program and from avoiding certain tasks such as heat tape application. He indicated that the final determination as to work restrictions should be made by Petitioner's physician. Wiedrich Dep Exh 4, pp. 39-40.

Petitioner testified he discussed the mechanics of heat tape application with the therapist who conducted the functional capacity evaluation. T. 73. Following the evaluation, his wrist pain and swelling increased. He informed Dr. Wiedrich of this. T. 74.

Petitioner returned to Dr. Wiedrich on November 9, 2011. The doctor noted that Petitioner had recently undergone a functional capacity evaluation and experienced significant pain and swelling for several days thereafter. The doctor's examination findings were unchanged. He reviewed the functional capacity evaluation with Petitioner and released Petitioner to restricted duty with lifting less than 20 pounds, no heat taping and frequent breaks. Wiedrich Dep Exh 3, pp. 28-29.

At the next visit, on December 5, 2011, Dr. Wiedrich noted that Petitioner was still experiencing pain and had not resumed working. On examination, he again noted a positive

Tinel's sign over the radial nerve and diffuse pain over the right wrist. He indicated Petitioner "should work within the confines of his restrictions or he could undergo vocational rehabilitation." T. 75. He instructed Petitioner to return to him in three months. Wiedrich Dep Exh 3, p. 30. He continued the previous work restrictions. Wiedrich Dep Exh 3, p. 31.

At Respondent's request, Dr. Papierski re-examined Petitioner on December 27, 2011. In his report of that date, Dr. Papierski noted that Petitioner complained of "mostly continuous pain with occasional sharp shooting pains in the dorsal, radial and ulnar aspects of the right wrist." He also noted that Petitioner was currently off work due to a 20-pound lifting restriction.

On right wrist re-examination, Dr. Papierski noted radial and dorsal tenderness, flexion of 35 degrees (versus 80 on the left), extension of 50 degrees (versus 80 on the left), 4/5 flexion and extension strength (versus 5/5 on the left) and tenderness with Finkelstein's testing. At his deposition, Dr. Papierski testified that Petitioner's right wrist flexion and extension measurements were "pretty close to the expected range of motion of someone who has had a proximal row carpectomy." He indicated that a proximal row carpectomy is a form of arthroplasty. It preserves some wrist range of motion while removing the arthritic portions of the wrist joint. RX 3 at 10. On right hand re-examination, Dr. Papierski noted tenderness with CMC range of motion.

Dr. Papierski obtained AP and hyper-pronated right wrist X-rays. He interpreted the films as showing absence of the proximal row of bones of the wrist "with the capitates settled nicely in the lunate facet of the distal radius." He saw "no further evidence of first carpometacarpal joint degenerative change."

Dr. Papierski indicated that he reviewed two different descriptions of the quality assurance operator position. The first, a Triune analysis performed for Respondent, indicated that the heaviest weight lifted or carried ranged from 15 to 20 pounds but also included an "activity table of information" indicating that 20 to 50 pounds had to be lifted in less than an hour. The second, a "revised" description, indicated that physical effort was "up to 30 pounds."

Citing the recent functional capacity evaluation, Dr. Papierski found Petitioner capable of resuming work as a quality assurance operator. He indicated that, while "there may be ongoing symptoms," there was nothing that would otherwise prevent Petitioner from resuming the job.

Dr. Papierski indicated that Petitioner would reach maximum medical improvement sometime in January 2012, six months after his most recent surgery. Papierski Dep Exh 2.

Petitioner testified that Dr. Papierski found him capable of returning to work as a quality assurance operator. T. 76.

On January 9, 2012, Cornacchione sent Petitioner's counsel a letter indicating that Petitioner was scheduled to resume full duty on Monday, January 18, 2012. T. 76-77. PX 7.

Petitioner testified he resumed his quality assurance job on about January 16, 2012. This job paid $23.53 per hour, more than his previous job. He was guaranteed 42.5 hours of work per week. He received the extra hours beyond the standard 40 per week in exchange for working through lunch instead of taking a half-hour lunch break. T. 78.

Petitioner testified he did not undergo any additional training before he started working on January 16, 2012. His duties were the same as those he had attempted to perform on May 23, 2011. T. 78. As soon as he started heat taping on January 16, 2012, he felt his right wrist give way again. Ron Stidham was his foreman at that time. Stidham was the foreman assigned to Line 4, the line to which Petitioner was assigned. Stidham answered to Jared Warrick. Petitioner testified he was supposed to report any injury or concern to Stidham as of January 16, 2012. T. 81. He notified Stidham of his wrist problem. A third individual was also present during his conversation with Stidham. This person was either Alex Aguirre or a younger quality control employee whose name Petitioner could not recall. T. 79. Over Respondent's objection, Petitioner testified that, after he told Stidham his wrist had popped again, Stidham said, "well, there is nothing I can do – go up front and sit in the QC office until we report to Jared." T. 82. Petitioner went to the office. Later that day he met with Jared Warrick, Teresa Grilli and Ralph Rosillo, a union representative. Petitioner testified that Warrick is Respondent's plant manager and Grilli is Respondent's personnel manager. T. 83-84. During the meeting, he explained how he had re-injured his wrist. In response, Grilli said there was nothing she could do, that Petitioner was performing a job he had selected and that if he was not able to perform this job, he should go home and call his attorney. T. 84.

Petitioner testified he was off work from January 18, 2012 through February 6, 2012. He indicated he did not receive temporary total disability benefits during this interval. T. 85. He resumed working in quality assurance, at the same rate of pay, on February 7, 2012. During the first week of work, he watched videos of safety-related classes he had missed while he was off work. He did not experience any physical problems while sitting and watching the videos. T. 85-86.

Petitioner testified his right wrist "popped again" on February 13, 2012, immediately after he started applying heat tape. He reported this to Ron Stidham. At Stidham's direction, he went to the QC office and waited. Later the same day, he met with Jared Warrick, Teresa Grilli, Ralph Rosillo and possibly Rich Hart, another union representative. During this meeting, he was told his injury was "ongoing" and he "should just contact [his] attorney." T. 87.

Petitioner testified that, at Respondent's direction, he went to Alexian Brothers Corporate Health on February 13, 2012. He underwent drug and alcohol tests at this facility. The test results were negative. PX 1, pp. 119-120. He also saw Dr. Baksinski, who examined him, recommended he return to Dr. Wiedrich and released him to light duty with splint usage and no use of the right hand "until cleared by orthopedic surgeon." PX 1, p. 122.

The February 13, 2012 records from Alexian Brothers Corporate Health reflect that Petitioner reported experiencing a pop in his right wrist while applying heat tape that morning. The records also reflect that Petitioner complained of throbbing pain radiating to his right thumb. Dr. Baksinski examined Petitioner and ordered right wrist X-rays. The X-rays showed post-surgical changes and "no significant change" since the previous X-rays of December 1, 2010. PX 1, p. 112. Dr. Baksinski diagnosed a wrist sprain/strain. She dispensed a wrist splint and instructed Petitioner to wear the splint at work and home. She also prescribed Ibuprofen. She noted Petitioner planned to follow up "with ortho specialist of his choice." She released Petitioner to work with use of the splint and no use of the right hand. PX 1, pp. 107-110.

Petitioner testified that Respondent did not offer him work within the restrictions imposed by Dr. Baksinski. T. 89. Eventually, after his attorney requested payment (PX 9), Respondent paid him temporary total disability benefits for the period February 13, 2012 through March 12, 2012. T. 89-90.

On February 20, 2012, Petitioner returned to Dr. Wiedrich and reported re-injuring his right wrist while performing taping. Petitioner indicated he had undergone an examination and X-rays following this re-injury.

On examination, Dr. Wiedrich noted diffuse tenderness about the right wrist, slight swelling and no ecchymosis. He reviewed the recent X-rays and interpreted them as showing no arthritis and good overall positioning of the capitate on the radius. He commented that Petitioner "likely had a sudden shift of his capitate on the radius resulting in the stretching or tearing of some scar tissue." He prescribed Naprosyn, released Petitioner to work with no use of the right hand and instructed Petitioner to return in one week. Wiedrich Dep Exh 3, pp. 33-37.

On February 24, 2012, Petitioner's counsel sent a letter via facsimile to Respondent's counsel, requesting that Respondent either provide accommodated duty or bring Petitioner current on benefits. PX 9. Petitioner testified Respondent did not offer him accommodated duty after February 24, 2012. T. 91-92.

Petitioner testified he cancelled an appointment with Dr. Wiedrich on February 27, 2012 so that he could see Dr. Papierski for a re-examination, at Respondent's request. T. 91-92.

When Dr. Papierski re-examined Petitioner on February 27, 2012, he noted that Petitioner had recently resumed working but had experienced a "sudden snap and pain" in his right wrist on his third attempt at a taping procedure.

Dr. Papierski's examination findings were very similar to those documented on December 27, 2011 except that the doctor noted right wrist flexion of 40 degrees, right wrist extension of 45 degrees and 5/5 flexion and extension strength in both wrists.

Dr. Papierski indicated he reviewed a February 13, 2012 accident investigation form along with updated medical records. He described the recent incident as a "temporary sprain or strain of the right wrist, possibly with some scar tissue popping loose, but [with no evidence of] structural damage." He indicated that, while Petitioner might experience swelling and tenderness for a couple of weeks, he would be able to resume his quality assurance duties three to four weeks after the February 13, 2012 temporary aggravation. He indicated Petitioner would likely reach maximum medical improvement from this aggravation within six to eight weeks of February 13, 2012. Papierski Dep Exh 3.

Petitioner next saw Dr. Wiedrich on March 5, 2012. In his note of that date, the doctor indicated that Petitioner again complained of pain over the dorsal and radial aspects of his right wrist. He re-examined Petitioner and obtained right wrist X-rays. He interpreted the films as showing good position of the proximal row carpectomy, no arthritis at the capital radius joint and no fractures or dislocations. He described Petitioner as having "aggravated his wrist on the job." He indicated he wanted to review a job video in order to determine whether Petitioner could perform taping. He instructed Petitioner to return in three to four weeks. He released Petitioner to work with no taping and lifting less than 20 pounds. He sent copies of his note and work restrictions to both Cornicchione and the nurse case manager. Wiedrich Dep Exh 3, p. 43. [The Arbitrator notes that all of Dr. Wiedrich's treatment notes and disability slips are accompanied by letters directed to Cornicchione, with each letter indicating that a carbon copy was being sent to the nurse case manager. Wiedrich Dep Exh 3.]

Petitioner testified that a nurse case manager accompanied him when he visited Dr. Wiedrich. The nurse case manager typically came into the doctor's examining room after the doctor finished his examination but while Petitioner was still present. T. 94.

On March 7, 2012, Petitioner's counsel sent Respondent's counsel a letter via facsimile enclosing Dr. Wiedrich's restrictions and requesting that Respondent either accommodate the restrictions or pay benefits. PX 10. On March 12, 2012, Respondent's counsel sent Petitioner's counsel a letter via facsimile indicating Petitioner was to report to work at 7:00 AM the following day. PX 11.

Petitioner testified he received no temporary total disability benefits after March 7, 2012. T. 97. He reported to work on March 13, 2012, as directed. He was again assigned to quality assurance at an hourly rate of $23.53 and with a guarantee of 42.5 hours per week. T. 98.

Petitioner testified that, on March 13, 2012, he was required to perform heat taping. When he attempted to perform this task, he again felt his wrist pop. He recalled Jared Warrick, a co-worker and a foreman, either Ron Stidman or Ricky (whose last name he could not recall), being present when his wrist popped. T. 98-99. These individuals were present for the express purpose of watching him perform the heat taping. T. 99. After his wrist popped, he experienced swelling and pain. He reported this to the foreman. At the foreman's direction, he then went to the QC office, where he subsequently met with Jared Warrick and Teresa Grilli.

Petitioner testified that Warrick and Grilli did not allow him to go to the company clinic on this occasion. They told him it was a "continuance of an old injury." T. 100-101. Using his own insurance, he went to Alexian Brothers Corporate Health that day. He received a splint and was released to work with no use of the right hand "until cleared by hand specialist." T. 100-101. Petitioner testified that Respondent did not offer him work within these restrictions. T. 101.

Petitioner returned to Dr. Wiedrich on March 19, 2012. T. 101. The doctor's note of that date reflects that Petitioner reported experiencing pain and popping in his right wrist the first day he attempted to resume regular duty. The doctor also noted that Petitioner complained of significant swelling and ecchymosis about the wrist.

On examination, Dr. Wiedrich noted no visible ecchymosis, no crepitation with motion and "no change in the overall swelling of the wrist from prior visits." He indicated that, "with loading and shucking of the wrist," there was "a slight give and pop consistent with [Petitioner's] descriptions of popping." He indicated this was "coming from the area of the radius and capitates due to the congruency of the PRC." He described Petitioner as stable overall. He released Petitioner to work "within the restraints of the FCE." He instructed Petitioner to return to him as needed. Wiedrich Dep Exh 3, pp. 45-46.

Petitioner testified that, on March 19, 2012, he demonstrated the mechanics of heat taping to Dr. Wiedrich at the doctor's request. Petitioner further testified his wrist popped when he simulated this activity. T. 102.

Petitioner testified that Respondent did not offer him work within Dr. Wiedrich's restrictions after March 19, 2012. T. 102.

Petitioner testified that, during this time period, he told Jared Warrick, Teresa Grilli and union representatives he felt he could perform another job at Respondent, namely a janitor position. Respondent did not allow him to perform this position. T. 103.

On May 1, 2012, Dr. Papierski issued an addendum, after reviewing updated records from Dr. Wiedrich along with a Triune job analysis and video dated November 30, 2011. Dr. Papierski noted that the comment section in the job analysis described lifting of no more than 20 pounds but that "the tables themselves actually indicate lifting up to between 26 and 50 pounds occasionally."

Dr. Papierski noted that he had been asked to review this information "with particular attention to the heat taping activity." He indicated there was nothing about Petitioner diagnoses that would preclude him from performing heat taping but conceded Petitioner "may have some symptoms during this kind of activity, as well as other activities utilizing the right hand." Papierski Dep Exh 4.

On May 1, 2012, Edward Rascati, a certified vocational rehabilitation counselor who has operated EJR Consulting, Inc. since 1996 (Rascati Dep Exh 1), prepared a labor market survey at

Cornacchione's request. T. 113. RX 2 at 4-5. Rascati's report reflects he prepared the survey after learning that Petitioner's attorney "would not allow [a] vocational evaluation." Rascati indicated he reviewed records from Drs. Wiedrich and Papierski, along with various job descriptions, Petitioner's job application and work history and the functional capacity evaluation of November 3, 2011. RX 2 at 5-6.

In his report of May 1, 2012, Rascati noted that Petitioner graduated from Steinmetz High School in 1975 and began working for Respondent in May 1978. Rascati indicated that Petitioner held various positions and underwent various types of training while working for Respondent.

Rascati identified fourteen prospective jobs in his report. Six of these jobs appear to be with/through staffing agencies. Most of the hourly salaries (where identified) range from $10 to $16. One machine operator job paid $19 to $22 per hour, "DOE" [depending on experience.] Rascati indicated the average hourly salary was $13.84. RX 2 at 9. Several of the jobs required lifting of 30 to 35 pounds. One job, a meter reader position with Nicor Gas, required "an extreme amount of physical activity," with the applicants needing to be able to walk between 5 and 10 miles per day "while bending, stretching, kneeling and crawling."

Rascati noted that he could not obtain details regarding some of the jobs. In some instances, he relied on the Dictionary of Occupational Titles, which classifies both slitter operator and embosser jobs as "light," meaning that a maximum of 20 pounds is involved.

Rascati also noted there was "some discrepancy" as to Petitioner's lifting requirements, with Dr. Wiedrich referencing the functional capacity evaluation but simultaneously indicating Petitioner was restricted to lifting less than 20 pounds. PX 16. At his deposition, Rascati testified he attempted to use the lifting restrictions recommended by both Dr. Wiedrich [20 pounds] and Dr. Papierski [30 pounds] in identifying prospective jobs for Petitioner. RX 2 at 17-18.

At his deposition, Rascati opined that Petitioner could potentially secure a job earning up to $22 per hour. Rascati further opined that the lowest end of the salary range was $11 per hour. RX 2 at 9-10.

Under cross-examination, Rascati testified that, if he were to consider only unskilled jobs for Petitioner, those jobs would pay between about $8.25 and $11.00 per hour. RX 2 at 11. Rascati testified he was unaware that Respondent had denied Petitioner's request for vocational rehabilitation prior to his involvement. RX 2 at 13. He agrees with the proposition that a physician needs to review the results of a functional capacity evaluation in order to determine a patient's work restrictions. RX 2 at 16. Rascati indicated he was attempting to maximize Petitioner's 20+ years in manufacturing in preparing the labor market survey. RX 2 at 18. He did not discuss Petitioner's restrictions with any of the prospective employers he contacted. He simply inquired as to those employers' needs. RX 2 at 19. He typically "casts a wide net" when looking for prospective employers, especially when he has no opportunity to

perform a vocational evaluation in person. RX 2 at 21. Cornicchione and Respondent's counsel informed him Petitioner had difficulty performing the "heat taping" aspect of the quality assurance job. Dr. Wiedrich restricted Petitioner from performing heat taping. RX 2 at 22-23. If the prospective jobs he identified in his labor market survey required the type of heat taping Petitioner was required to perform for Respondent, those jobs would not be suitable for Petitioner. RX 2 at 23. If Petitioner contacted all of the prospective employers in the survey and received no responses, that would not prompt him to conclude the jobs were unsuitable. He would need more information as to the nature of Petitioner's contact with the employers. RX 2 at 25.

On May 4, 2012, the Arbitrator conducted a pre-trial at the request of both parties. During this pre-trial, counsel for both parties discussed Petitioner's quality assurance job and, specifically, the heat taping aspect of that job, with the Arbitrator. The Arbitrator did not review any job description or video. The Arbitrator recommended that Petitioner try the job again but use his left hand to perform the heat taping.

On May 9, 2012, Respondent's counsel sent Petitioner's counsel a letter directing Petitioner to report to work at 7:00 AM on May 14, 2012. Petitioner testified he did not report to work at that time because he developed a severe case of food poisoning. He called off work for that reason. T. 105. He reported to work on May 16, 2012 and was assigned to quality assurance. He could not recall whether he actually performed any work on that date. T. 105.

On the afternoon of May 17, 2012, Petitioner sought care at the Emergency Room at Northwest Community Hospital. T. 105. Petitioner indicated he had experienced cramping, diarrhea and vomiting since eating at a buffet the previous Saturday. The Emergency Room physician examined Petitioner, noting some epigastric tenderness. He diagnosed gastroenteritis. He instructed Petitioner to stay off work for three days. He indicated Petitioner could resume working on May 20, 2012, assuming he had not experienced a fever for 24 hours. PX 24.

Petitioner testified he saw his family physician, Dr. Small, on May 21, 23, 25 and 30, 2012. Petitioner testified that Dr. Small kept him off work during this period. T. 106.

Petitioner testified he resumed working on May 31, 2012, a Friday, with the understanding that he was going to attempt to use his non-dominant left hand to perform heat taping. Petitioner testified this attempt did not go well. He lacked the necessary strength and coordination and could not apply the tape properly. Petitioner explained that, when heat tape is not put on correctly, it falls off, requiring the worker to "go back and re-do it on the next stitch that they run through the line when they connect two coils together." T. 107. Petitioner testified he resumed using his right hand to perform the heat taping after he was unable to effectively use his left. As soon as he tried using his right hand, the hand became swollen and painful. T. 108.

Petitioner testified he reported to work on Monday, June 3, 2012, and again tried to use his left hand to perform heat taping. He again encountered difficulty and switched to his right hand, at which point his right wrist became painful and swollen. He managed to work only a few hours. He reported his symptoms to his foreman, Ron Stidham, and then sat in the quality control office at Stidham's direction. T. 109. Later the same day, he met with Jared Warrick, Teresa Grilli and Ralph Rosillo. He testified he told these individuals he tried to do heat taping with his left hand but was unsuccessful. He also reported developing symptoms after switching to his right hand. Teresa Grilli reiterated that he was performing a job he had chosen to perform. She also indicated that, if he could not perform this job, he should go home and call his attorney. T. 110. Petitioner testified he asked whether he would be fired if he went home and was told "no." T. 111. Grilli's E-mail of June 4, 2012 confirms Respondent did not fire Petitioner.

On June 6, 2012, Petitioner returned to Alexian Corporate Health and saw Dr. Reese, who imposed work restrictions. T. 111. Records in PX 13 and PX 15 show that Petitioner complained of right arm pain with associated weakness and tingling on June 6, 2012. Dr. Reese prescribed Naproxen and advised Petitioner to see a hand surgeon and use a wrist spica splint he already had. He released Petitioner to restricted duty with the following restrictions to remain in place "until cleared by hand specialist": limited use of the right hand with splint usage, no tight gripping with the right hand and maximum lifting of 5 pounds with the right hand. There is no evidence indicating Petitioner returned to Dr. Wiedrich or any other "hand specialist" after June 6, 2012. Dr. Wiedrich's last note is dated March 19, 2012.

On June 13, 2012, Petitioner's counsel sent Respondent's counsel a letter asking Respondent to provide Petitioner with work within Dr. Reese's restrictions. PX 13. Petitioner testified that, at no point after June 13, 2012 did Respondent accommodate the restrictions or resume paying benefits. T. 112-113. On July 11, 2012, Petitioner's counsel sent Respondent's counsel a letter indicating that Petitioner would begin a self-directed job search if Respondent did not provide accommodated duty by July 20, 2012. PX 14.

Petitioner testified that, as of about July 20, 2012, he began looking for light duty, after preparing a resume with the help of his daughter. He identified PX 17 as the resume. T. 115. [The Arbitrator notes that the second page of the resume reflects Petitioner obtained a high school diploma in 1975.] He kept logs concerning his job contacts. His daughter prepared most of these logs. PX 17.

Petitioner testified that, in the course of his job search, he contacted all but one of the potential employers listed in Ed Rascati's labor market survey. [He explained he did not contact one employer, a gas company, because the job required extensive crawling.] None of the employers he contacted asked to interview him or made him an offer. T. 114-115.

Petitioner testified that, eventually, he found a job with Sunset Pools and Spas. He began working for this company on about May 12, 2013. The job involved driving a truck to various residences and using a "skimmer" to skim leaves off of swimming pools. He earned

$9.00 per hour. His hours varied. During the busy season, he worked 48 hours per week. T. 117. He continued experiencing pain and swelling in his right wrist and thumb but his symptoms were "not as bad." T. 117.

Petitioner testified that Sunset Pools and Spas laid him off on October 17, 2013. He knew the job was coming to an end prior to the layoff. T. 118.

PX 18 consists of a group of Petitioner's weekly paycheck stubs from Sunset Pools and Spas covering the period May 12, 2013 through September 7, 2013.

Petitioner testified he did not receive any benefits from Respondent during the period he worked for Sunset Pools and Spas. After the layoff, he began looking for work again. He had to stop looking for work on about November 25, 2013 because his daughter, who has an addiction problem, had to be hospitalized and he had to assume custody of his grandchildren. His wife could not take care of their grandchildren because she was working. T. 120. Although his daughter got out of the hospital on December 24, 2013, he had to continue caring for his grandchildren after that date because his daughter is taking mandatory classes at the direction of DCFS. Those classes can take place anytime during the day or evening. At such point that his daughter finishes the classes and regains custody of the children, he will resume looking for work.

Petitioner identified PX 18 as a collection of stubs from the paychecks he received from Sunset Pools and Spas. T. 117-118.

Petitioner testified he met with Ed Pagella, a vocational rehabilitation counselor, at his attorney's request. Following the meeting, which took place on October 18, 2013, Pagella made recommendations and devised a vocational plan. T. 118. [In his report of October 24, 2013, Pagella, a certified vocational counselor, indicated he interviewed Petitioner and reviewed a number of documents, including treatment records and Rascati's labor market survey. He agreed, "in part," with Rascati's opinion that Petitioner could earn an average of $13.84 per hour but went on to say that the average fell "more in line with $12.50 per hour." He recommended that Petitioner complete a "career assessment inventory" to determine his vocational interests" and that Petitioner undergo training in job seeking and interviewing techniques. PX 21.]

Petitioner testified he wants Respondent to initiate vocational rehabilitation under Mr. Pagella's direction. T. 122.

Petitioner identified PX 19 as a group of medical bills from Alexian Brothers Corporate Health, Dr. Wiedrich and Alexian Brothers Medical Group. To his knowledge, these bills remain outstanding. If, in fact, some or all of the bills have been paid, he will not claim them. T. 119.

Under cross-examination, Petitioner testified he recalls experiencing popping in his wrist while performing heat taping as a quality assurance operator on May 23, 2011. He had

performed a quality assurance job for Respondent about 25 or 28 years earlier. T. 126. As of May 23, 2011, he was being trained as he worked. Two individuals, Alex Aguirre and a younger man, were training him. T. 127. Petitioner then acknowledged he could not be sure about the date May 23, 2011. Assuming that is the correct date, he could not recall if he finished his shift that day.

Petitioner initially testified it is "possible" the conference call took place on May 23, 2011. A few minutes later, he indicated he received this call in May or June of 2010, after his first surgery. It was his seniority that afforded him the right to choose among 10 or 11 jobs that had become available due to a plant closure. T. 131. It was Bob Grilli who denied his request to have a day or two to think about his choice. He chose the quality assurance job because it was the highest-paying job of the ones he was offered and because he had performed the job in the past. When he performed this job in the past, the job involved heat taping. T. 132.

Petitioner recalled discussing his concerns about heat taping with the individual who performed his November 3, 2011 functional capacity evaluation. That individual noted his concerns. Dr. Wiedrich took this into consideration in setting work restrictions. T. 133.

Petitioner recalled calling off work on Monday, January 16, 2012, the day he was supposed to return to work. He called off work because he had had no sleep and was sick. T. 133. He believes he returned to work the next day and then spent a week watching safety videos, without actually performing any work. T. 134. When he went to work, he produced whatever restrictions Dr. Wiedrich has imposed. He did not produce restrictions dated November 2011. He believes he was offered short-term disability on January 17, 2012. T. 136. He may have watched safety videos on February 7, 2012. The following day, a Wednesday, he called off work because his wrist pain affected his sleep. T. 138. When he called in, he mentioned the lack of sleep but did not mention his wrist. T. 138. On Thursday, February 9, 2012, he underwent safety training. He cannot recall if he was scheduled to work on Friday, February 10, 2012. On Monday, February 13, 2012, he underwent training on the line and, soon thereafter, began developing pain and swelling in his hand. He went off work, sought care and received temporary total disability benefits through March 12, 2012. He believes he attempted to work on March 13, 2012. He would have started work at 7 AM that day. It "could be" that he complained to Jared Warrick of swelling and tingling in his hand at 7:15 AM on March 13, 2012. It is possible he made this complaint before he attempted to perform any work. T. 141. He returned to Dr. Wiedrich after March 13, 2012 and showed the doctor how he positioned his hand while applying heat tape. When he pushed his hand back, his wrist popped. He told the doctor: "this is what happens when my hand is forced back or my wrist is forced back in the opposite direction." T. 143. After the pre-trial, Respondent arranged for him to return to work to see if he could use his left hand to perform heat taping. T. 144. He called in sick on May 14, 2012. He could not recall whether he also called in sick on May 15, 2012. It is possible he presented to work on May 16, 2012 but left because he was feeling sick. T. 145-146. He lost two weeks of work due to food poisoning but cannot recall the exact dates he was off. He applied for, and received, short-term disability for this period. T. 146-147. He returned to work after this period. He last worked for Respondent on June 4, 2012. That day, he

informed his supervisor he was unable to perform the work. He attended a meeting later that day at which he was told he had to perform the job because he had chosen it. At this meeting, Teresa Grilli ultimately told him to go home and call his attorney. T. 148. He started looking for work at some point thereafter. He cannot recall the date he started his job search. Only the tenth page of his job search records is dated. His daughter's handwriting appears on the first nine pages. His handwriting appears on page ten. That page is dated May 3, 2013. That page shows he contacted Crown Services about a picker/packer job. He cannot recall whether he contacted this business via telephone or the Internet. He could not perform the job because of the weight limit. He learned of the job at Sunset Pools and Spas because a former friend, Scott Bianchi, worked there and told him the job fell within his restrictions. T. 152. When he worked at Sunset Pools and Spas, he drove an automatic van to various sites and used two different poles to skim leaves off pools. The poles were retractable. They extended from 8 to 16 feet. One was made of aluminum and the other was made of fiberglass. He used both hands to extend the pole and skim leaves. He used his thumbs to grasp the pole. He hardly had to move his wrists. He usually moved the pole forward and straight back but sometimes moved it side to side. The poles weighed no more than five pounds. He also had to attach a vacuum to the end of the pole and push it into the water. The vacuum weighed 10 to 15 pounds. The vacuum was used to clean the bottom of the pools. The pools were of varying depths. He had to push against the resistance of the water. T. 157. He probably cleaned about 8 to 10 pools per day. He worked five or six days a week. T. 158.

On redirect, Petitioner testified he physically demonstrated the heat tape activity to Dr. Wiedrich. When he did this, his wrist popped. He did not just verbally describe the job to the doctor. T. 159-160. He injured his wrist performing heat taping on March 13, 2012. T. 160. He did not like the idea of attempting the heat tape application with his left hand but he figured he would give it a try. He "did [his] best." T. 161. He attempted to perform the heat taping several times, per Dr. Papierski, even though he was violating Dr. Wiedrich's restrictions. He made these attempts because he wanted to work. T. 161. Dr. Atluri referred him to Dr. Wiedrich. At no point did he go to a doctor he had chosen completely on his own. T. 162. No one associated with Respondent ever told him why Respondent would not accommodate Dr. Wiedrich's restriction. T. 162. He "probably" started looking for work after July 20, 2012 but he "gets [his] dates mixed up." T. 163-164.

Jared Warrick testified on behalf of Respondent. Warrick testified he is currently the director of quality at Respondent's Elk Grove Village facility. In 2012, he was Respondent's plant manager. It was in May or June of 2010 that Petitioner selected a quality assurance position pursuant to the "effects bargaining agreement." This agreement evolved because one of Respondent's plants was closing. The agreement allowed "senior workers," such as Petitioner, to select available jobs so as to retain their seniority. T. 168. Warrick testified he did not become the plant manager until November 2010 and thus was not involved in the discussion that led to Petitioner choosing the quality assurance job. T. 169.

Warrick testified that Petitioner asked to speak with a manager upon arriving at work on January 17, 2012, following his third surgery. T. 174. Petitioner produced a doctor's note

indicating he could not perform heat taping and had a lifting restriction. The note was "old." Warrick discussed this with Teresa Grilli, Respondent's personnel manager. They decided to allow Petitioner to undergo video safety training so as to afford him time to produce more current documentation. Petitioner was able to provide this documentation. T. 175.

Warrick testified that, on March 13, 2012, he talked with Petitioner at 7:15 AM, before Petitioner had performed any work. He asked Petitioner how he was doing. Petitioner told him he had pain in his hand and did not know why he had been directed to return to work. Petitioner began working. The supervisor on duty watched him work, having been instructed to "make sure that all return to work are watched closely." Warrick also observed Petitioner working with Alex Aguirre. T. 172. Warrick observed Petitioner performing "T bends" and taking measurements. Petitioner did not voice any complaints while Warrick was observing him. T. 173. Later that morning, Petitioner "complained of pain again." Neither Warrick nor any supervisor was able to verify that Petitioner sustained a work injury that day. After Petitioner made the complaint, Warrick met with him and a union representative. Petitioner told them he was unable to perform the job.

Warrick, along with the Arbitrator, counsel and Petitioner, then viewed RX 5, a job video taken by Ruben Luna of Triune on or about November 30, 2011. T. 192. Warrick testified he was present when the video was taken. The video accurately depicts the duties involved in the quality assurance job. Warrick testified that the strips used during heat taping are "very tacky" and can be applied using only mild to light finger pressure. T. 177-178, 184. The tape does not have to line up exactly with the metal strip. Even if it is "slightly skewed," it will give an accurate temperature reading. T. 177-178, 190. Warrick testified he has applied heat tape on many occasions. He has filled in for an absent quality assurance operator on occasion. T. 179. The strips of tape are pre-cut into 2- to 3-inch lengths. The worker has to peel each strip off of a backing. He then places the tape on his radio, watch or gear so as to be ready to apply the tape to the metal strip when it arrives. T. 189. Warrick testified he completely disagrees with Petitioner's testimony that he had to use all of his available force to apply the tape. T. 185. Warrick testified he is right-handed. He has never attempted to use his left hand to apply the tape but he "absolutely" believes a worker could do this. T. 189-190.

Warrick testified that, 44 seconds into the video, Alex Aguirre can be seen opening packages of heat tape. T. 194. About 2 minutes and 27 seconds into the tape, Aguirre can be seen applying the heat tape. About 4 minutes and 23 seconds into the tape, Aguirre can be seen recording measurements. T. 196.

Warrick testified that a quality assurance operator can apply heat tape as little as once and as much as eight times during a single shift. The average is 4 to 5 applications per shift. T. 196-197. Each application involves the placement of two pieces of tape. T. 197. The video shows only one heat tape application. T. 198.

Warrick testified that the quality assurance job does not require any lifting over 20 pounds. Workers performing the job have to handle panels that weigh more than 20 pounds

but they "have a cart that they can use." T. 199. The actual lifting requirement is 25 pounds but Respondent considers that "with a single hand." T. 199.

Warrick testified he appears on the tape at the 10 minute, 45 second point. About four minutes later, Aguirre is again seen on the tape, performing a "T-bend." Warrick testified that a "T-bend" involves folding a coated metal strip over on itself and then taping it in order to check the adhesion of the coating to the strip. T. 201.

Under cross-examination, Warrick testified he began working for Respondent in April 2006, at which point Petitioner was working on the slitter. He cannot say whether Petitioner was a good worker because Petitioner did not report to him. T. 202. He did not review Petitioner's personnel file before taking the stand. T. 203. He became the plant manager in 2010. In preparation for the hearing, he reviewed E-mails involving Petitioner that were sent or received after he became the plant manager. One of Respondent's exhibits contains a timeline of events along with E-mails that substantiate this timeline. T. 208.

Warrick acknowledged that the video does not show all aspects of the quality assurance job. A quality assurance worker has to apply heat tape to two types of coaters: finish and prime. The video shows only a finish coater. The two coaters run at the same speed but there is more space on the finish coater on which to affix the heat tape. The video shows a finish coater operating at an "average" speed. T. 210-211. It also shows the standard type of heat tape. T. 212. It is probably easier to apply the non-standard type, i.e., the high temperature tape, because it is wider and affords "more of a grab." T. 213. The video, which is about 14 minutes long, shows only one heat tape application. The application takes place about 1 minute, 42 seconds into the video. Aguirre performs the application, with the whole process taking just a couple of seconds. T. 213. Aguirre's right hand can be seen traveling backward in a rapid motion as he applies the tape "because he was keeping tempo with the strip" as the strip moved overhead. T. 214. Petitioner would have had to perform the application the same way. Warrick testified he cannot say whether or not Petitioner's wrist popped when he tried to perform the application because he was not present to witness the event. T. 215-216. Warrick testified he could not recall exactly how many times Petitioner tried to perform the quality assurance job. On February 13, 2012, Petitioner made an attempt and reported that his wrist popped. An accident report was completed and Petitioner was sent to the clinic. T. 217. Warrick reviewed RX 14 and testified that this exhibit does not contain any doctor's note releasing Petitioner to heat taping. T. 219. Warrick testified he relies on Respondent's human resources department to review doctors' notes and provide return-to-work dates and restrictions. T. 220. On those occasions when Petitioner attempted to perform the quality assurance job, it was Teresa Grilli who provided the restrictions. Warrick testified he was not made aware that Dr. Wiedrich restricted Petitioner from performing heat taping. T. 222. If he had been aware of this restriction, he would not have put Petitioner back to work in quality assurance. The quality assurance job includes heat taping per the current job description but "there are things that can be done to evaluate." Petitioner was asked to attempt heat taping using his left hand. Petitioner made the attempt but reported this did not work well for him. Warrick testified he (himself) never had to use his non-dominant hand to perform heat taping

because he has no problems with his dominant hand. It would take "a little more time" for him to use his non-dominant hand because he would have to go around the coater. T. 225. On the video, Aguirre can be seen "shuffling" along in order to get to the point where the heat tape comes through. T. 225. The following exchange then occurred:

> "Q. Now, if the metal is running at faster speed, though, he probably would have to hurry down there in order to get there on time, correct?
>
> A: Or he could ask somebody else down there to read the heat tape.
>
> Q: Well, as long as there is somebody else down there to read the heat tape, couldn't that somebody else also be there helping Mr. Mays, helping put the heat tape on for him so he can do the other aspects of his job?
>
> A: That's a possibility, but you need to be able to perform all parts of the function yourself in case nobody else is available.
>
> Q: So if Mr. Mays cannot do the heat taping, then he cannot do that QA job, right?
>
> A: He is not fully qualified, no."

T. 226. Because Petitioner was undergoing "buddy training" when he returned to work in February, March and June 2012, he was being observed by Ron Stidham, the line supervisor, per Respondent protocol. T. 226-227. Stidham was involved in the meetings that were held in connection with Petitioner's attempts to return to work. T. 228. The E-mails in RX 16 would contain any statements Stidham made. T. 228.

Warrick testified that, at 7:15 AM on March 13, 2012, Petitioner told him he did not understand why he was at work that day. Petitioner also said, "look, I'm swollen," gesturing to his hand and wrist. T. 229. Petitioner did not mention Dr. Wiedrich's restriction at that time. T. 229.

Warrick testified that, in January 2012, he asked human resources to provide a more updated work release. It was at this point that Respondent had Petitioner undergo safety training, so as to allow Petitioner to obtain an updated release, which he did. T. 231. Petitioner did not perform any work on January 17, 2012. T. 235.

Warrick testified that, on the video, Aguirre can be seen folding metal over itself once. On some occasions, it is necessary to fold the metal over several times. More force has to be applied when folding the metal four or five times. T. 237. The video does not show Aguirre doing this type of folding. T. 237. Warrick testified that Petitioner told him he was having

difficulty doing "T bends." It would not be typical for a quality assurance operator to have someone else perform "T bending" because this is an integral task of the job. T. 238.

On redirect, Warrick testified he did not review records from Dr. Wiedrich or Dr. Papierski. Due to privacy laws, he does not review a worker's medical records in his capacity as plant manager. T. 239. Petitioner was not terminated on the last day he worked. T. 240.

Petitioner was recalled to the stand. Petitioner testified that some of the heat tapes used in quality assurance are lightweight, tacky and easy to apply. Those are the tapes that are shown on the video. They are white in color. Other tapes, which are orange and high temperature, are two to three times thicker and much more difficult to apply. These orange tapes were used "all the time." Sometimes there is water on the metal strip. This makes it "impossible" to get the heat tape to adhere. Sometimes there is light powder on the metal strip and you have to "really push" to get the heat tape to stick. T. 246. The prime coater, which is not shown on the video, affords only a couple of feet of room within which to position yourself while trying to apply the heat tape. T. 247. The video shows Aguirre's arm getting "jerked" backward as he applied the heat tape. T. 249. The goal is to get the heat tape positioned in the center of the coil. Some jobs require application of two to three pieces of heat tape at a time. It is "basically impossible" to do this without using both hands. On the occasion when he made an attempt to perform heat taping using his left hand, his body was further under the strip, which made it more difficult for him to extricate himself so he could move to the next position. T. 251. When the metal strip is running 100 feet a minute, it is somewhat easier to apply the heat tape. When the strip is moving at a faster pace, such as 200 feet a minute, it is more difficult. The speed of the strip on the video is not designated. T. 252. The video showed Aguirre performing a "cero T" bend. This is equivalent to folding a piece of paper. Most of the jobs do not call for "cero T" bends. They require folding of thicker pieces of metal. A "4T" bend involves folding a ¼-inch piece of metal, which is difficult to do. You have to stand up, grab the strip and push it down, using your weight. T. 253.

Petitioner testified the video does not accurately depict heat taping or T bends. T. 254.

Under cross-examination, Petitioner acknowledged that the type of heat tape application shown on the video does take place at Respondent's facility but it is not the only type. The strip shown in the video does not look like it is moving very fast. T. 255. On the day he attempted to use his left hand to perform heat taping, he worked for only an hour or two. He is basing his testimony on this attempt. With the prime coater, the strip moves at a height that is a little less than 5 feet. With the finish coater, the height is a little over 5 feet. Regardless of which coater was involved, he had to stoop while performing heat taping. T. 257.

Warrick testified he is aware Petitioner underwent a functional capacity evaluation but he does not recall when the evaluation was performed. T. 233.

As indicated above, Respondent offered into evidence Dr. Papierski's deposition of April 12, 2013. Dr. Papierski acknowledged that Petitioner never described heat taping to him in any

detail. RX 3 at 14. He viewed a video of the quality assurance operator job. RX 3 at 15-16. Based on the video, he saw no need to restrict Petitioner from performing heat taping with his right hand. He did not believe that Petitioner would be inhibited from using his non-dominant left hand to perform heat taping. RX 3 at 18.

Under cross-examination, Dr. Papierski testified a worker may be able to continue a particular work activity despite experiencing symptoms from that activity, so long as the activity does not further damage or aggravate the underlying condition. RX 3 at 22. He conceded that Petitioner might become symptomatic while performing the quality assurance operator job. RX 3 at 23. Based on the measurements he took, Petitioner's right wrist flexion is "about 50 percent of what would be considered normal." RX 3 at 25. In February 2012, he noted tenderness with attempted Finkelstein's maneuvering along with a 5 millimeter gap in "pulp to palm" testing. He had not noted these findings when he examined Petitioner in December 2011. RX 3 at 26-28. These findings were indicative of a decrease in flexibility and range of motion of Petitioner's right thumb. RX 3 at 29. The job description he reviewed did not describe the type of tape Petitioner applied. Nor did it describe the force required to apply the tape. He did not receive any samples of the heat tape. RX 3 at 31-32. He cannot recall what type of motion was needed in order to remove the tape from the dispenser. RX 3 at 37. Heat taping could cause Petitioner to become symptomatic. RX 3 at 38. The person who performed the November 2011 functional capacity evaluation noted that Petitioner grimaced when performing a heat tape simulation. RX 3 at 36-37.

Dr. Papierski testified he did not have enough information to determine the underlying cause of the "popping pain" Petitioner complained of when doing heat taping. RX 3 at 39-40. If a patient of his experienced pain with a particular activity, he might or might not restrict the person from performing that activity. Before imposing a restriction, he would want to know what was going on from an anatomical perspective that was causing a sensation of popping and/or pain. RX 3 at 42. It would be reasonable to restrict a patient from performing that activity while investigating that underlying cause. RX 3 at 42. When he examined Petitioner, there was no indication that Petitioner was feigning or exaggerating his symptoms. RX 3 at 43. It was "potentially" reasonable for Dr. Wiedrich to restrict Petitioner from heat taping. RX 3 at 43.

Dr. Papierski testified that the initial work accident was a competent cause of the right wrist injury Petitioner sustained. The treat Petitioner received was reasonable. Petitioner's injury resulted in some degree of permanent impairment. It was appropriate to restrict Petitioner from full activity. RX 3 at 44.

Dr. Papierski testified that, on average, he devotes about 10 to 15 percent of his time to conducting independent medical examinations. RX 3 at 45, 51. About 90 percent of the examinations he performs are requested by employers or insurance carriers. RX 3 at 51. He and Dr. Atluri worked at the same hand surgery practice but not concurrently. RX 3 at 52. He left that practice because he was in the Air Force reserve and got called to active duty. RX 3 at 53. When scar tissue tears loose, following a surgery such as a de Quervain's release,

symptoms such as bleeding, swelling and pain can occur. These symptoms typically improve over time. RX 3 at 54. It is not typical for additional scar tissue to form during this improvement period. RX 3 at 55. If scar tissue tears loose, it can potentially re-adhere and later pop loose again. RX 3 at 56. This would be rare but not unheard of. RX 3 at 56.

[CONT'D]

Harold Mays v. Material Science Corporation
10 WC 18126, 12 WC 17345-6 (consolidated)

Arbitrator's Credibility Assessment – see decision in 12 WC 17346

Arbitrator's Conclusions of Law – 10 WC 18126

Is Petitioner entitled to temporary total disability benefits?

In 10 WC 18126, Petitioner claims an initial interval of temporary total disability running from May 3, 2010 through May 16, 2011. Respondent stipulates Petitioner was temporarily totally disabled from May 3, 2010 through May 22, 2011. Arb Exh 1. The Arbitrator finds that Respondent is bound by its stipulation, pursuant to Walker v. Industrial Commission, 345 Ill.App.3d 1084, 1088 (4th Dist. 2004), and awards temporary total disability benefits from May 3, 2010 through May 22, 2011, a period of 55 weeks.

Petitioner claims a second interval of temporary total disability from May 24, 2011 through January 16, 2012. Respondent stipulates to a slightly different interval, running from May 25, 2011 through January 15, 2012. Arb Exh 1. Petitioner testified he reported to work on May 23, 2011 and attempted, unsuccessfully, to perform the quality assurance job. Petitioner further testified he did not report to work the following day. Records in evidence reflect that Dr. Atluri imposed restrictions on May 26, 2011 after finding that Petitioner was unable to perform a light duty job. Based on those records and Respondent's binding stipulation, the Arbitrator finds a start date of May 25, 2011 rather than May 26, 2011. The Arbitrator finds that Petitioner was temporarily totally disabled thereafter through January 15, 2012. The Arbitrator declines to find that Petitioner was temporarily totally disabled on January 16, 2012. Petitioner was scheduled to return to work that day but called in sick. T. 133. RX 14, p. 1.

Petitioner claims a third interval of temporary total disability from January 18, 2012 through February 6, 2012. The parties agree that Petitioner presented to work on January 17, 2012. It appears likely to the Arbitrator that Petitioner presented Dr. Wiedrich's work restrictions of November 2011 on that date, with Respondent characterizing these restrictions as "old," and that Respondent allowed Petitioner to watch safety videos rather than perform any actual work while in the process of procuring updated restrictions. Once Dr. Wiedrich faxed over updated restrictions, Respondent made a determination that Petitioner's current status was "no longer WC," and gave Petitioner the option of receiving short-term disability. In the Arbitrator's view, Respondent may have had some basis for disputing the updated restrictions, based on the opinions Dr. Papierski expressed on December 27, 2011, but did not have a basis for suddenly characterizing Petitioner's right wrist condition as non-work-related. [The Arbitrator notes that Respondent stipulated to causation in 10 WC 18126. Arb Exh 1.] Following January 17, 2012, Petitioner was off work through February 6, 2012. For the reasons set forth in the decision in 12 WC 17346 (in particular, the concessions Dr. Papierski made at his

deposition), the Arbitrator relies on Dr. Wiedrich rather than Dr. Papierski on the issue of work restrictions. The Arbitrator finds that Petitioner was temporarily totally disabled from January 18, 2012 through February 6, 2012, a period of 2 6/7 weeks.

In summary, in 10 WC 18126, the Arbitrator finds that Petitioner was temporarily totally disabled during three intervals: 1) May 3, 2010 through May 22, 2011 (55 weeks); 2) May 25, 2011 through January 15, 2012 (33 5/7weeks); and 3) January 18, 2012 through February 6, 2012 (2 6/7 weeks). These three intervals total 91 4/7 weeks.

The Arbitrator addresses Petitioner's claims for additional temporary total disability, temporary partial disability, maintenance, medical expenses and vocational rehabilitation in the decision in 12 WC 17346.

Is Petitioner entitled to penalties and fees in 10 WC 18126?

Petitioner maintains that Respondent acted unreasonably and vexatiously in failing to accommodate Dr. Wiedrich's restrictions and declining to pay temporary total disability benefits from January 18, 2012 through February 6, 2012. While the Arbitrator has elected to rely on Dr. Wiedrich rather than Dr. Papierski on the issue of work restrictions, and while the Arbitrator views Dr. Papierski as making significant concessions during his April 12, 2013 deposition [see additional analysis in the decision in 12 WC 17346], the Arbitrator is unable to conclude that Respondent is liable for penalties and fees in 10 WC 18126. Dr. Papierski specifically addressed Petitioner's work capacity in his December 27, 2011 report, after re-examining Petitioner and reviewing multiple documents. It appears to the Arbitrator that Respondent compared that report with the updated work restrictions Petitioner provided on or after January 17, 2012. It is not as if Respondent lacked any basis for believing Petitioner could perform heat taping.

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

15IWCC0021

MAYS, HAROLD
Employee/Petitioner

Case# **12WC017345**

10WC018126
12WC017346

MATERIAL SCIENCE CORPORATION
Employer/Respondent

On 4/3/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.06% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0009 ANESI OZMON RODIN NOVAK KOHEN
JOHN POPELKA
161 N CLARK ST 21ST FL
CHICAGO, IL 60601

0766 HENNESSY & ROACH PC
EDWARD HENNESSY
140 S DEARBORN 7TH FL
CHICAGO, IL 60603

Harold Keith Mays v. Material Science Corporation
10 WC 18126, 12 WC 17345-6 (consolidated)

Arbitrator's Findings of Fact Relative to All Cases

Petitioner was 55 years old as of the January 21, 2014 hearing. He goes by the name "Keith." He testified he is right-handed. He is 6 feet, 3 inches tall. As of the hearing, he weighed 280 pounds. He testified he has put on about 30 pounds since December 2009. T. 25-26.

In 10 WC 18126, the parties agree Petitioner was injured at work on December 21, 2009. Arb Exh 1. Petitioner testified he worked for Respondent for 31 years before this accident. T. 22. He held a variety of jobs during that period. He was a member of the steelworkers' union throughout his tenure. T. 26. His job titles included quality control worker, skid and box builder, paint room worker, Line 4 pay-off, Line 3 crew chief, slitter assistant, slitter crew chief and embosser helper. T. 26-28.

Petitioner testified he worked as a slitter helper as of December 21, 2009. As a slitter helper, he did packaging and operated a Jeep and forklift. He used a variety of tools, including banders, razor blades and knives. The bander was used to apply bands around large coils of steel or aluminum. These coils weighed between 20 and 45,000 pounds. T. 23-24. He routinely lifted skids that weighed around 50 or 60 pounds. He typically moved these skids by hand "because it was quicker." T. 23. If a skid weighed more than 60 pounds, he used the forklift to move it. He spent about 60 to 70 percent of each workday on his feet and about 30% operating the Jeep. T. 25.

Petitioner testified that, on December 21, 2009, one of his co-workers "backed up [a forklift] really quick," striking a "tilter" in the process. Petitioner described the tilter as a machine that is 8 feet tall and weighs thousands of pounds. The tilter sat on the floor between two large safety plates that were bolted to the ground. When the co-worker struck the tilter, one of the plates broke loose and "swung out," catching the back of Petitioner's feet and swinging Petitioner backward through the air. Petitioner testified his back and right elbow struck the tilter as he swung backward. As he started falling downward, he tried to grab a bar with his right hand but his hand "slipped off." He landed on concrete, striking his right elbow and the right side of his wrist. T. 32.

Petitioner testified he felt pain in his back, right wrist and right arm immediately after the accident. He noticed that his right elbow was bleeding. T. 33.

Petitioner denied injuring his low back prior to December 21, 2009. He had injured his right wrist and hand before that date but those injuries consisted only of cuts. T. 33.

Petitioner testified he saw Dr. McAndrew at Alexian Brothers Corporate Health Services [hereafter "Corporate Health"] the same day he was injured. Respondent sent him to this

facility. T. 34-35. He underwent drug and alcohol testing there. The test results were negative. Dr. McAndrew examined him and sent him to another facility for X-rays. T. 34-35.

The Corporate Health records of December 21, 2009 set forth a consistent account of the work accident. The records reflect that Petitioner primarily complained of his right wrist and hand but also complained of back pain. Petitioner indicated he struck the back of his right wrist. He complained of "throbbing and tingling" in his right hand. PX 1, p. 3. On right wrist examination, Dr. McAndrew noted pain over the snuffbox area, mild swelling and a full range of motion. He also noted the possibility of a foreign body in the thenar area. Right elbow and right wrist X-rays showed no evidence of fracture or dislocation. Right hand X-rays showed no evidence of fracture or dislocation and no definite evidence of a radio-opaque foreign body. PX 1, pp. 10-12. Dr. McAndrew diagnosed contusions of the right wrist, right elbow and back. He prescribed Ibuprofen and ice applications. He released Petitioner to light duty with no lifting over 10 pounds with the right hand, limited gripping/grasping/pinching with the right hand and overall lifting/pushing/pulling limited to 20 pounds. PX 1, p. 6.

Petitioner testified he began performing light duty after December 21, 2009. He wore a splint constantly and "went to work in pain." His wrist "kept getting worse and worse." T. 36.

Petitioner returned to Corporate Health on January 5, 2010 and again saw Dr. McAndrew. T. 36. The doctor noted that Petitioner was still experiencing back and right elbow soreness but primarily complained of right wrist pain and numbness in his fingers.

Dr. McAndrew re-examined Petitioner and prescribed new right wrist X-rays with navicular views. He refilled the Ibuprofen and provided Petitioner with a wrist splint. He released Petitioner to light duty with lifting/pushing/pulling with the right arm limited to 10 to 20 pounds, no climbing, limited gripping/grasping with the right hand and no pounding or hammering with the right hand. He stressed the importance of adhering to the restrictions and instructed Petitioner to follow up on January 13, 2010. He indicated he "left VM for T. Grilli re: importance of follow RTW." PX 1, p. 18.

The new right wrist X-rays, performed on January 5, 2010, showed "mild degenerative type subchondral cysts" but no definite evidence of acute fracture or dislocation. The radiologist indicated that an MRI should be given consideration "given the history of persistent pain." PX 1, p. 19.

Petitioner returned to Corporate Health on January 13, 2010, as directed, and again saw Dr. McAndrew. The doctor noted that Petitioner was wearing his wrist splint and that he complained of wrist pain that worsened with use and episodes of numbness in the first, second and third fingers of his right hand.

On right wrist examination, Dr. McAndrew noted pain over the distal radius, no swelling and a full range of motion. He described Tinel's and Phalen's testing as negative. PX 1, p. 23.

Dr. McAndrew again diagnosed a right wrist contusion. He described Petitioner's back and elbow problems as "resolved." He recommended that Petitioner see a hand specialist. He instructed Petitioner to continue taking the Ibuprofen and wearing the splint. He released Petitioner to light duty with right hand lifting/carrying limited to 15 pounds and limited use of the right hand and arm. PX 1, pp. 25-26.

Petitioner saw Dr. Atluri, a hand surgeon, on January 20, 2010. Dr. Atluri sent a report to Teresa Grilli of Respondent the same day. The report sets forth a consistent account of the December 21, 2009 work accident. Dr. Atluri noted that Petitioner's back and elbow symptoms had resolved but that he was still experiencing pain in his right hand and wrist, especially at the base of the thumb, along with occasional tingling shooting into the dorsal hand and thumb. He also noted that Petitioner denied any prior right hand problems.

On right wrist examination, Dr. Atluri noted limited range of motion, swelling with mild tenderness over the scapholunate interval, tenderness at the anatomic snuff box and first dorsal extensor compartment, maximum tenderness at the thumb CMC joint, tenderness at the distal pole of the scaphoid, negative Finkelstein's testing, positive thumb CMC grind, pain but no clunking with Watson's testing and "nearly full digital motion but [inability] to make a tight fist due to pain." PX 1, p. 34.

Dr. Atluri obtained right wrist X-rays, including scaphoid views. He indicated the films showed no obvious fractures or carpal mal-alignment.

Dr. Atluri's impression was "right wrist derangement." He suspected a ligamentous injury and could not rule out an occult scaphoid fracture. He prescribed a right wrist MRI and converted Petitioner to a forearm-based thumb spica splint. PX 1, pp. 31-32. He instructed Petitioner to wear this splint at home and work. He released Petitioner to light duty with lifting/carrying/pushing/pulling limited to 5 pounds, limited gripping/grasping with the right hand and splint usage. He instructed Petitioner to return after the MRI. PX 1, pp. 33, 35.

The right wrist MRI, performed without contrast on January 27, 2010, showed a "small joint effusion dorsal to the distal scaphoid compatible with mild synovitis." The radiologist indicated that the triangular fibrocartilage and scapholunate ligament appeared to be intact. He also indicated that the MRI had to be performed on a 0.3 T MRI "due to claustrophobia." PX 1, pp. 147-148.

Petitioner returned to Dr. Atluri on February 3, 2010. The doctor described the MRI as a "poor quality study." He described the MRI as showing no fractures or evidence of Kienbock's disease. He indicated the MRI was "otherwise non-diagnostic." He also indicated he was "still concerned about a possible ligament injury" but recommended another six weeks of conservative care. He stated he would consider performing an arthroscopy if Petitioner remained symptomatic at that point. He prescribed occupational therapy and continued the previous work restrictions. PX 1, pp. 36-39.

At the next visit, on March 17, 2010, Dr. Atluri noted that Petitioner continued to complain of right wrist pain and also complained of "increased numbness in the thumb, index and middle fingers."

On examination, Dr. Atluri noted tenderness at the thumb CMC joint, positive thumb CMC grind with some crepitus and positive digital compression testing over the carpal tunnel. He prescribed an EMG and continued the previous work restrictions. T. 40. PX 1, pp. 40-43

Dr. Barbara Heller, a physiatrist, performed EMG/NCV testing of Petitioner at Occspecialists on April 1, 2010. Dr. Heller interpreted the EMG/NCV as providing "electrodiagnostic evidence of a moderate sensory and motor primarily demyelinating carpal tunnel syndrome or median nerve entrapment neuropathy at the right wrist. PX 2, p. 6.

Petitioner returned to Dr. Atluri on April 7, 2010 and complained of increased numbness and tingling in his right hand. The doctor reviewed the EMG/NCV results. On examination, he noted a positive Tinel's over the carpal tunnel and over the dorsal radial sensory nerve with tenderness along the dorsal radial aspect of the wrist and distal forearm. He also noted a positive Watson, although "no significant tenderness over the dorsal wrist."

Dr. Atluri's impression was: carpal tunnel syndrome, Wartenberg syndrome and right wrist derangement. He indicated he still suspected a ligamentous injury. He noted that Petitioner had undergone four months of conservative care without resolution of his symptoms. He discussed various surgical options, including a carpal tunnel release and dorsal radial sensory nerve decompression. He noted that Petitioner agreed to undergo surgery. He continued the previous work restrictions. PX 1, pp. 44-48.

On May 3, 2010, Dr. Atluri operated on Petitioner's right wrist at Alexian Brothers Medical Center. T. 41. The surgery consisted of a right wrist arthroscopy with debridement of a TFCC tear, an open carpal tunnel release, a dorsal radial sensory nerve neurolysis and an open radial tunnel release. In his operative report, Dr. Atluri noted that the scapholunate ligament was "bulging" but not torn and that the TFCC "had a radial-sided tear with irregular flaps." He also noted that the dorsal radial sensory nerve was "healthy in appearance distally" but "demyelinated and flattened along the edge of the brachioradialis tendon." Proximal dissection revealed that the nerve was dymyelinated "even beyond the brachioradialis tendon." PX 3, pp. 42-44. PX 3. Following the surgery, Dr. Atluri instructed Petitioner to stay off work and avoid using his right hand. PX 3, p. 12.

Petitioner testified he began losing time from work as of the May 3, 2010 surgery. He initially received temporary total disability benefits. T. 41.

Petitioner testified he underwent occupational therapy at Alexian Occupational Clinic from May 10, 2010 through August 19, 2010. T. 41. He continued seeing Dr. Atluri during this time. T. 42.

On May 26, 2010, Dr. Atluri noted that Petitioner described his finger symptoms as improved but still complained of pain in the forearm and hand. On examination, the doctor noted that Petitioner could not make a fist. He also noted swelling and diffuse tenderness throughout the hand and forearm. He recommended that Petitioner continue therapy. He released Petitioner to work with no use of the right hand or arm. PX 1, pp. 52-56.

Petitioner testified he obtained some benefit from the surgery. Petitioner also testified that Respondent was unable to accommodate Dr. Atluri's restriction of no use of the right hand or arm. T. 42-43.

On June 23, 2010, Dr. Atluri noted that Petitioner's forearm pain had diminished but that he was still experiencing pain in the wrist, "particularly at the radial aspect of the wrist along with some tingling at the dorsal thumb." He prescribed additional therapy and continued the previous work restriction. PX 1, pp. 59.

On August 4, 2010, Dr. Atluri noted that Petitioner had plateaued in therapy and reported being unable to progress past 3 pounds due to wrist pain.

On examination, the doctor noted tenderness at the dorsal wrist near the scapholunate interval, a positive TFC grind with some crepitus, mild tenderness over the first extensor compartment, a negative Finkelstein's test, pain with wrist motion past 30 degrees of extension and 55 degrees of flexion, weak grip strength and pain with forceful gripping.

Dr. Atluri advised Petitioner that only a total wrist arthrodesis would completely eliminate Petitioner's pain. He viewed a limited arthrodesis as a better option, function-wise. He also viewed a proximal row carpectomy as a reasonable option. He indicated Petitioner might require permanent restrictions postoperatively. T. 44. He discontinued therapy (T. 43), continued the previous restriction and noted that Petitioner planned to return in two weeks. PX 1, pp. 62-65.

In his note of August 18, 2010, Dr. Atluri indicated that Petitioner opted for a proximal row carpectomy. He also indicated he warned Petitioner that this surgery would not eliminate all of the symptoms. He continued the previous restriction. PX 1, pp. 66-70.

Petitioner testified he decided to undergo surgery as of August 18, 2010 but told Dr. Atluri he wanted to obtain a second opinion concerning his surgical options. T. 44-45. He called the workers' compensation carrier and asked if there was a doctor they could recommend. They recommended he see Dr. Papierski. T. 44.

On September 29, 2010, Petitioner returned to Dr. Atluri. Petitioner reported that he was still awaiting surgical authorization and that he was scheduled to see Dr. Papierski for an IME. On examination, Dr. Atluri noted pain with range of motion and "positive Watson's tenderness radially and dorsally." He continued the previous restriction. PX 1, pp. 72-75.

At Respondent's request, Petitioner saw Dr. Papierski for a Section 12 examination on September 30, 2010. Dr. Papierski is a board certified orthopedic surgeon with added qualification in hand surgery. He is also a certified medical examiner. RX 3 at 4-5. Papierski Dep Exh 1.

Dr. Papierski's report concerning his September 30, 2010 examination is not in evidence. At his April 12, 2013 deposition, Dr. Papierski testified he reviewed Dr. Atluri's note of August 18, 2010 in connection with that examination. He viewed Dr. Atluri's various surgical recommendations as reasonable. His own recommendation "included trying to isolate where pain in [Petitioner's] wrist might be coming from," via injecting local anesthetic into various areas of the wrist "to see which areas of the wrist would be getting relief of pain." He also felt that Petitioner's condition "would probably merit additional treatment." He believed consideration could be given to an extensor tendon compartment release, an arthroscopic resection of the distal ulna or proximal hamate or a radioscapholunate arthrodesis, "another type of limited fusion." RX 3 at 7-8.

On October 20, 2010, Petitioner discussed Dr. Papierski's findings and recommendations with Dr. Atluri. Dr. Atluri noted that Petitioner indicated he was interested in surgery rather than additional conservative care. Petitioner again opted to undergo a proximal row carpectomy. Dr. Atluri continued the previous restriction. PX 1, pp. 76-80.

On November 19, 2010, Dr. Atluri performed a right wrist proximal row carpectomy and a right wrist posterior interosseous neurectomy at Alexian Brothers Medical Center. PX 3. Post-operative X-rays revealed "good carpal alignment with post-surgical changes." They also revealed that the capitates was "well seated in the lunate fossa." PX 3, pp. 80-81. Following the surgery, Dr. Atluri instructed Petitioner to stay off work and avoid using his right hand and arm. PX 3, p. 67.

Petitioner testified that, at some point after the November 19, 2010 surgery, he noticed he was still experiencing pain in his right thumb and wrist. T. 47.

On November 24, 2010, Petitioner began a course of therapy at Alexian Occupational Clinic. On that date, the evaluating therapist noted that Petitioner's right hand and wrist "presented with severe pitting edema." The therapist utilized massage techniques in an effort to reduce this edema. PX 1, p. 139.

Petitioner testified that, on November 30, 2010, he was performing therapy when he noticed and heard a popping noise in his right wrist and thumb. He had never experienced this before. T. 48. Within half an hour of hearing the noise, he began experiencing swelling. T. 48-49. The therapist applied ice to the affected area. T. 49.

The following day, December 1, 2010, Dr. Atluri noted that Petitioner complained of a "pop" while exercising. The doctor obtained right wrist X-rays. He described the X-rays as looking okay. He instructed Petitioner to continue wearing the splint and attending therapy.

On December 29, 2010, Petitioner returned to Dr. Atluri. On examination, Dr. Atluri noted significantly less swelling but very reduced grip strength. He indicated Petitioner could flex his fingers to mid-palm but could not make a fist. He instructed Petitioner to wean off the splint and continue therapy. He continued the previous restriction. PX 1, pp. 84-87.

On January 26, 2011, Dr. Atluri injected cortisone into Petitioner's right thumb CMC joint. He directed Petitioner to wear a thumb CMC joint splint at night and continue therapy. He imposed new restrictions of no lifting/carrying/pushing/pulling, limited grasping/pinching and splint usage. PX 1, pp. 88-93.

At the next visit, on February 23, 2011, Petitioner reported no improvement secondary to the injection. He continued to complain of pain at the base of his thumb. Dr. Atluri recommended that Petitioner continue therapy for another month and then potentially transition to work conditioning. He continued the previous restrictions. PX 1, pp. 94-99.

On April 5, 2011, Dr. Atluri recommended that Petitioner transition to work conditioning. PX 1.

On April 7, 2011, Petitioner underwent a work conditioning evaluation at AthletiCo. The evaluating therapist recorded a history of the December 21, 2009 injury and subsequent care. The therapist also noted that Petitioner was subject to work restrictions, that no light duty was available and that Petitioner was "looking to return to work with quality assurance duties." Petitioner reported a pain rating of 1-2/10 at rest that increased to 7-8/10 "during forceful gripping and lifting activities." On examination, the therapist noted grip strength of 60 pounds on the right (versus 100 on the left), three-point pinch strength of 16 pounds on the right (versus 26 on the left) and lateral pinch strength of 20 pounds on the right (versus 29 on the left). PX 5.

Petitioner returned to Dr. Atluri on May 3, 2011. The doctor noted that Petitioner was making good progress in work conditioning. He indicated he had been provided with a written description of a job that required lifting up to 25 pounds. He released Petitioner to this job on a part-time basis for the next two weeks, indicating that Petitioner should continue work conditioning while performing the new job four hours per day. He indicated Petitioner could resume full duty after undergoing work conditioning for two weeks. PX 1, pp. 101.

Petitioner testified that work conditioning was beneficial in terms of increasing his overall activity level but it did not help his wrist or thumb. He continued experiencing swelling and pain. T. 53-54. A work conditioning note dated May 11, 2011 reflects Petitioner continued to complain of thumb pain and planned to see another surgeon in about a month. The same note reflects Petitioner reported a "pop" in his shoulder while performing "lat pull-downs" and cancelled a session scheduled for the following day due to shoulder pain. PX 5, pp. 56-57.

On May 12, 2011, Marianne Cornacchione, a claim supervisor affiliated with CCMSI [hereafter "Cornacchione"], sent the following note to Petitioner's counsel via facsimile:

> "Mr. Mays has been returned to work full duty as of Monday 5/23/11. Please see attached and advise your client."

PX 6, p. 1. Attached to this note is a letter bearing the same date from Cornacchione to Petitioner's counsel referencing and attaching Dr. Atluri's note of May 3, 2011. PX 6, p. 3. In the letter, Cornacchione indicated she authorized the additional two weeks of work conditioning the doctor prescribed on May 3, 2011. She further indicated that, per Dr. Atluri, Petitioner would be capable of full duty once the two weeks had been completed, that she would continue paying temporary total disability benefits through May 22, 2011 and that Respondent had scheduled Petitioner to return to work on Monday, May 23, 2011. PX 6, p. 2.

A document in the AthletiCo records (PX 5) reflects that Petitioner attended work conditioning through May 12, 2011 and was subsequently discharged from work conditioning based on a case manager's report that he resumed full duty on May 16, 2011. PX 5, p. 59. Petitioner did not testify to resuming full duty on that date. He testified Dr. Atluri never released him to full duty. T. 54-55. He further testified he began performing a quality assurance job at Respondent on May 23, 2011. On direct examination, he testified he started this job after participating in a speaker phone conference call with Bob and Teresa Grilli of Respondent and some union officials. He testified he did not anticipate receiving this call. During the call, he was told that the Respondent plant where he had previously worked had closed and that he had to choose a job to perform "at the next plant." The callers presented him with ten or eleven jobs, including a quality assurance job, to choose from. Petitioner testified he asked the callers whether he could have a day or two to think about his choice but was told he had to make a decision on the spot. He chose the quality assurance job because it paid the most and because he had worked in quality assurance for Respondent many years earlier. T. 59.

Petitioner testified that, when he presented to the quality assurance job on May 23, 2011, he was told he "had to learn how to do the job in ten days." An individual named Alex Aguirre trained him. T. 59-60.

Petitioner testified that one of his duties in the quality assurance job was to apply "heat tape" to the bottom of a metal strip that moved along an elevated line. He was required to apply heat tape the first day he worked in quality assurance. T. 60-61. Petitioner described heat tape as a "four-inch sticky piece of tape" that reads the temperature of metal "once it goes into ovens." T. 61. The line along which the metal strip moved was about 4 to 4 ½ feet above ground level. Petitioner testified he had to "duck a couple of feet to get under the strip." The rate at which the strip moved along the line varied, depending on the job. Petitioner testified the strip could move as slowly as 100 feet per minute to 260-300 feet per minute. T. 61. Petitioner indicated he had to use his thumb and index finger in order to affix the heat tape

to the moving metal strip. He had to "really push down" on the heat tape in order to make sure it stuck to the metal strip. T. 63-64. Petitioner would position himself under the line with his right elbow at a 90 degree angle away from his body and his right thumb pointing up. When the moving metal strip got close to him, and was almost overhead, he would forcefully push the heat tape onto the bottom of the strip and then keep pushing as the strip continue moving. His right thumb would move backward in the process. T. 64.

Petitioner testified that, on his first attempt at applying heat tape on the morning of May 23, 2011, he felt his right wrist pop and experienced pain in his right wrist and thumb. T. 65. He moved out from underneath the line and tried to shake off his pain, "hoping it was nothing major." He then ran down to the finish coater in order to apply another piece of heat tape. When he applied this piece, his right wrist "really popped." Petitioner testified he immediately reported this to his foreman. The foreman told him to sit down for a few minutes. He sat down but "the swelling started almost immediately" and his pain increased. T. 66. He did not resume working that day. T. 66-67.

Petitioner testified he was off work from May 24, 2011 through January 6, 2012. He received temporary total disability benefits during this period. T. 67.

On May 26, 2011, Petitioner returned to Dr. Atluri. The doctor noted that Petitioner had started a new light duty job but was complaining of increased thumb pain secondary to a number of work activities. Petitioner reported that the new job position required him to "apply pressure with his thumb and perform some pinching maneuvers." On examination, Dr. Atluri noted tenderness at the thumb CMC joint and a little bit of intermittent clicking with CMC grind.

Dr. Atluri obtained new X-rays. He interpreted the films as showing mild arthrosis at the thumb CMC joint and post-surgical changes.

Dr. Atluri indicated "it does not appear as if [Petitioner] can perform his light duty work due to his thumb pain." He did not feel the thumb arthritis warranted additional surgery. He noted that Petitioner "does feel better in the splint but states he cannot perform his necessary work duties with the splint in place."

Dr. Atluri advised Petitioner to use the splint for symptom control. He noted Petitioner was seeing Dr. Wiedrich for a second opinion. He indicated he thought this was an "excellent idea." He recommended that Petitioner return to him after seeing Dr. Wiedrich. He released Petitioner to restricted duty with splint usage. PX 1, pp. 102-103. PX 6.

Petitioner testified that, on May 26, 2011, he asked Dr. Atluri who he should see for his thumb after Dr. Atluri told him he was not a thumb expert and "couldn't do anything for the thumb area." According to Petitioner, it was at this point in the conversation that Dr. Wiedrich's name came up. Dr. Atluri recommended he see Dr. Wiedrich. T. 69.

Petitioner first saw Dr. Wiedrich on July 13, 2011. Dr. Wiedrich is a fellowship-trained hand surgeon. He achieved board certification in plastic surgery in 1994 and added qualification in hand surgery the following year. PX 4 at 6. He has been an assistant professor at Northwestern University's medical school since 1992. Wiedrich Dep Exh 2.

Dr. Wiedrich's initial note of July 13, 2011 reflects that "no data" was available as to the identity of the referring physician.

Dr. Wiedrich's note sets forth a consistent history of the December 21, 2009 work accident and subsequent care. He indicated that Petitioner complained of right thumb pain, which prevented him from working, and difficulty with right wrist extension. On range of motion testing, he noted dorsal flexion/proximal flexion of 30/55 in the right wrist and 65/65 in the left wrist and radial deviation/ulnar deviation of 5/20 in the right wrist and 20/30 in the left wrist. On right wrist examination, he noted mild dorsal wrist swelling and well-healed incisions about the wrist and forearm. He also noted radial styloid tenderness and mild tenderness of the first CMC joint. He obtained Fluoro Scan images and interpreted them as showing "evidence of radial trapezoid abutment." He indicated Petitioner "would benefit from a radial styloidectomy." He described his "plan" as follows: "IME report." He completed a disability certificate releasing Petitioner to restricted duty with limited use of the right hand, specifically "no forceful lifting and radial deviation." He indicated Petitioner should be off work if these restrictions could not be met. Wiedrich Dep Exh 3, p. 7.

Dr. Wiedrich wrote to Cornacchione and the nurse case manager, Gloria Torres, R.N., the same day, enclosing his note, describing Petitioner's work restrictions and indicating he anticipated Petitioner would reach maximum medical improvement three months after a radial styloidectomy. Wiedrich Dep Exh 3, p. 8.

On August 19, 2011, Dr. Wiedrich operated on Petitioner's right wrist at Northwestern Memorial Hospital. The surgery consisted of a radial styloidectomy and a release of the first dorsal compartment. Wiedrich Dep Exh 3, pp. 10-11.

Petitioner testified he did not notice much improvement following the surgery. He "still had the pain." T. 70.

Petitioner followed up with Dr. Wiedrich three days postoperatively. The doctor described Petitioner's radial nerve function as good. He placed Petitioner in a short arm thumb spica splint and instructed him to start occupational therapy and return in ten days. He released Petitioner to work with no use of the right hand. Wiedrich Dep Exh 3, pp. 12-15. Petitioner testified Respondent did not accommodate this restriction. T. 70-71.

At the next visit, on September 1, 2011, Petitioner complained to Dr. Wiedrich of pain with radial/ulnar deviation. He indicated he was wearing the splint most of the time. The doctor prescribed therapy and continued the previous work restriction. Wiedrich Dep Exh 3, pp. 16-19.

Petitioner testified he participated in therapy at Athletico through November 3, 2011. The therapy did not help much. He continued to experience pain and swelling. He had to apply ice to his right hand after each therapy session. T. 71-72.

On October 4, 2011, Dr. Wiedrich noted that Petitioner was still complaining of wrist pain and reported "marginal improvement." T. 72. On right wrist examination, the doctor noted diffuse tenderness, no significant swelling, no crepitus and a positive Tinel sign down the length of the entire superficial radial nerve. He obtained X-rays, which showed evidence of the surgeries and no significant arthritis. He prescribed four more weeks of therapy, followed by a functional capacity evaluation. He continued the previous work restriction. Wiedrich Dep Exh 3, pp. 20-25.

Petitioner underwent a functional capacity evaluation at AthletiCo on November 3, 2011. In his report of that date, the evaluator described Petitioner as cooperative throughout the evaluation. He described Petitioner's effort as variable and noted "minor inconsistency to the reliability and accuracy of [Petitioner's] reports of pain and disability." He noted "maximum voluntary effort" with Jamar grip strength testing. Petitioner's grip strength was 60.67 pounds on the right versus 92 on the left. Petitioner successfully completed a pegboard manual dexterity test but exhibited signs of discomfort during this test. Based on both a DOT job description and a job description provided by Respondent, the evaluator found Petitioner capable of "returning to his pre-injury job demands as a quality assurance analyst." He noted, however, that Petitioner described heat tape application as his "biggest concern" with the target job position. He indicated he was "unable to test specific work tasks related to application of heat tape" but that Petitioner was able to participate in "workflow simulation" twice. He indicated that, during this simulation, Petitioner reported right wrist fatigue and "demonstrated signs of discomfort." Near the end of his report, he stated that Petitioner might benefit from a pain program and from avoiding certain tasks such as heat tape application. He indicated that the final determination as to work restrictions should be made by Petitioner's physician. Wiedrich Dep Exh 4, pp. 39-40.

Petitioner testified he discussed the mechanics of heat tape application with the therapist who conducted the functional capacity evaluation. T. 73. Following the evaluation, his wrist pain and swelling increased. He informed Dr. Wiedrich of this. T. 74.

Petitioner returned to Dr. Wiedrich on November 9, 2011. The doctor noted that Petitioner had recently undergone a functional capacity evaluation and experienced significant pain and swelling for several days thereafter. The doctor's examination findings were unchanged. He reviewed the functional capacity evaluation with Petitioner and released Petitioner to restricted duty with lifting less than 20 pounds, no heat taping and frequent breaks. Wiedrich Dep Exh 3, pp. 28-29.

At the next visit, on December 5, 2011, Dr. Wiedrich noted that Petitioner was still experiencing pain and had not resumed working. On examination, he again noted a positive

Tinel's sign over the radial nerve and diffuse pain over the right wrist. He indicated Petitioner "should work within the confines of his restrictions or he could undergo vocational rehabilitation." T. 75. He instructed Petitioner to return to him in three months. Wiedrich Dep Exh 3, p. 30. He continued the previous work restrictions. Wiedrich Dep Exh 3, p. 31.

At Respondent's request, Dr. Papierski re-examined Petitioner on December 27, 2011. In his report of that date, Dr. Papierski noted that Petitioner complained of "mostly continuous pain with occasional sharp shooting pains in the dorsal, radial and ulnar aspects of the right wrist." He also noted that Petitioner was currently off work due to a 20-pound lifting restriction.

On right wrist re-examination, Dr. Papierski noted radial and dorsal tenderness, flexion of 35 degrees (versus 80 on the left), extension of 50 degrees (versus 80 on the left), 4/5 flexion and extension strength (versus 5/5 on the left) and tenderness with Finkelstein's testing. At his deposition, Dr. Papierski testified that Petitioner's right wrist flexion and extension measurements were "pretty close to the expected range of motion of someone who has had a proximal row carpectomy." He indicated that a proximal row carpectomy is a form of arthroplasty. It preserves some wrist range of motion while removing the arthritic portions of the wrist joint. RX 3 at 10. On right hand re-examination, Dr. Papierski noted tenderness with CMC range of motion.

Dr. Papierski obtained AP and hyper-pronated right wrist X-rays. He interpreted the films as showing absence of the proximal row of bones of the wrist "with the capitates settled nicely in the lunate facet of the distal radius." He saw "no further evidence of first carpometacarpal joint degenerative change."

Dr. Papierski indicated that he reviewed two different descriptions of the quality assurance operator position. The first, a Triune analysis performed for Respondent, indicated that the heaviest weight lifted or carried ranged from 15 to 20 pounds but also included an "activity table of information" indicating that 20 to 50 pounds had to be lifted in less than an hour. The second, a "revised" description, indicated that physical effort was "up to 30 pounds."

Citing the recent functional capacity evaluation, Dr. Papierski found Petitioner capable of resuming work as a quality assurance operator. He indicated that, while "there may be ongoing symptoms," there was nothing that would otherwise prevent Petitioner from resuming the job.

Dr. Papierski indicated that Petitioner would reach maximum medical improvement sometime in January 2012, six months after his most recent surgery. Papierski Dep Exh 2.

Petitioner testified that Dr. Papierski found him capable of returning to work as a quality assurance operator. T. 76.

On January 9, 2012, Cornacchione sent Petitioner's counsel a letter indicating that Petitioner was scheduled to resume full duty on Monday, January 18, 2012. T. 76-77. PX 7.

Petitioner testified he resumed his quality assurance job on about January 16, 2012. This job paid $23.53 per hour, more than his previous job. He was guaranteed 42.5 hours of work per week. He received the extra hours beyond the standard 40 per week in exchange for working through lunch instead of taking a half-hour lunch break. T. 78.

Petitioner testified he did not undergo any additional training before he started working on January 16, 2012. His duties were the same as those he had attempted to perform on May 23, 2011. T. 78. As soon as he started heat taping on January 16, 2012, he felt his right wrist give way again. Ron Stidham was his foreman at that time. Stidham was the foreman assigned to Line 4, the line to which Petitioner was assigned. Stidham answered to Jared Warrick. Petitioner testified he was supposed to report any injury or concern to Stidham as of January 16, 2012. T. 81. He notified Stidham of his wrist problem. A third individual was also present during his conversation with Stidham. This person was either Alex Aguirre or a younger quality control employee whose name Petitioner could not recall. T. 79. Over Respondent's objection, Petitioner testified that, after he told Stidham his wrist had popped again, Stidham said, "well, there is nothing I can do – go up front and sit in the QC office until we report to Jared." T. 82. Petitioner went to the office. Later that day he met with Jared Warrick, Teresa Grilli and Ralph Rosillo, a union representative. Petitioner testified that Warrick is Respondent's plant manager and Grilli is Respondent's personnel manager. T. 83-84. During the meeting, he explained how he had re-injured his wrist. In response, Grilli said there was nothing she could do, that Petitioner was performing a job he had selected and that if he was not able to perform this job, he should go home and call his attorney. T. 84.

Petitioner testified he was off work from January 18, 2012 through February 6, 2012. He indicated he did not receive temporary total disability benefits during this interval. T. 85. He resumed working in quality assurance, at the same rate of pay, on February 7, 2012. During the first week of work, he watched videos of safety-related classes he had missed while he was off work. He did not experience any physical problems while sitting and watching the videos. T. 85-86.

Petitioner testified his right wrist "popped again" on February 13, 2012, immediately after he started applying heat tape. He reported this to Ron Stidham. At Stidham's direction, he went to the QC office and waited. Later the same day, he met with Jared Warrick, Teresa Grilli, Ralph Rosillo and possibly Rich Hart, another union representative. During this meeting, he was told his injury was "ongoing" and he "should just contact [his] attorney." T. 87.

Petitioner testified that, at Respondent's direction, he went to Alexian Brothers Corporate Health on February 13, 2012. He underwent drug and alcohol tests at this facility. The test results were negative. PX 1, pp. 119-120. He also saw Dr. Baksinski, who examined him, recommended he return to Dr. Wiedrich and released him to light duty with splint usage and no use of the right hand "until cleared by orthopedic surgeon." PX 1, p. 122.

The February 13, 2012 records from Alexian Brothers Corporate Health reflect that Petitioner reported experiencing a pop in his right wrist while applying heat tape that morning. The records also reflect that Petitioner complained of throbbing pain radiating to his right thumb. Dr. Baksinski examined Petitioner and ordered right wrist X-rays. The X-rays showed post-surgical changes and "no significant change" since the previous X-rays of December 1, 2010. PX 1, p. 112. Dr. Baksinski diagnosed a wrist sprain/strain. She dispensed a wrist splint and instructed Petitioner to wear the splint at work and home. She also prescribed Ibuprofen. She noted Petitioner planned to follow up "with ortho specialist of his choice." She released Petitioner to work with use of the splint and no use of the right hand. PX 1, pp. 107-110.

Petitioner testified that Respondent did not offer him work within the restrictions imposed by Dr. Baksinski. T. 89. Eventually, after his attorney requested payment (PX 9), Respondent paid him temporary total disability benefits for the period February 13, 2012 through March 12, 2012. T. 89-90.

On February 20, 2012, Petitioner returned to Dr. Wiedrich and reported re-injuring his right wrist while performing taping. Petitioner indicated he had undergone an examination and X-rays following this re-injury.

On examination, Dr. Wiedrich noted diffuse tenderness about the right wrist, slight swelling and no ecchymosis. He reviewed the recent X-rays and interpreted them as showing no arthritis and good overall positioning of the capitate on the radius. He commented that Petitioner "likely had a sudden shift of his capitate on the radius resulting in the stretching or tearing of some scar tissue." He prescribed Naprosyn, released Petitioner to work with no use of the right hand and instructed Petitioner to return in one week. Wiedrich Dep Exh 3, pp. 33-37.

On February 24, 2012, Petitioner's counsel sent a letter via facsimile to Respondent's counsel, requesting that Respondent either provide accommodated duty or bring Petitioner current on benefits. PX 9. Petitioner testified Respondent did not offer him accommodated duty after February 24, 2012. T. 91-92.

Petitioner testified he cancelled an appointment with Dr. Wiedrich on February 27, 2012 so that he could see Dr. Papierski for a re-examination, at Respondent's request. T. 91-92.

When Dr. Papierski re-examined Petitioner on February 27, 2012, he noted that Petitioner had recently resumed working but had experienced a "sudden snap and pain" in his right wrist on his third attempt at a taping procedure.

Dr. Papierski's examination findings were very similar to those documented on December 27, 2011 except that the doctor noted right wrist flexion of 40 degrees, right wrist extension of 45 degrees and 5/5 flexion and extension strength in both wrists.

Dr. Papierski indicated he reviewed a February 13, 2012 accident investigation form along with updated medical records. He described the recent incident as a "temporary sprain or strain of the right wrist, possibly with some scar tissue popping loose, but [with no evidence of] structural damage." He indicated that, while Petitioner might experience swelling and tenderness for a couple of weeks, he would be able to resume his quality assurance duties three to four weeks after the February 13, 2012 temporary aggravation. He indicated Petitioner would likely reach maximum medical improvement from this aggravation within six to eight weeks of February 13, 2012. Papierski Dep Exh 3.

Petitioner next saw Dr. Wiedrich on March 5, 2012. In his note of that date, the doctor indicated that Petitioner again complained of pain over the dorsal and radial aspects of his right wrist. He re-examined Petitioner and obtained right wrist X-rays. He interpreted the films as showing good position of the proximal row carpectomy, no arthritis at the capital radius joint and no fractures or dislocations. He described Petitioner as having "aggravated his wrist on the job." He indicated he wanted to review a job video in order to determine whether Petitioner could perform taping. He instructed Petitioner to return in three to four weeks. He released Petitioner to work with no taping and lifting less than 20 pounds. He sent copies of his note and work restrictions to both Cornicchione and the nurse case manager. Wiedrich Dep Exh 3, p. 43. [The Arbitrator notes that all of Dr. Wiedrich's treatment notes and disability slips are accompanied by letters directed to Cornicchione, with each letter indicating that a carbon copy was being sent to the nurse case manager. Wiedrich Dep Exh 3.]

Petitioner testified that a nurse case manager accompanied him when he visited Dr. Wiedrich. The nurse case manager typically came into the doctor's examining room after the doctor finished his examination but while Petitioner was still present. T. 94.

On March 7, 2012, Petitioner's counsel sent Respondent's counsel a letter via facsimile enclosing Dr. Wiedrich's restrictions and requesting that Respondent either accommodate the restrictions or pay benefits. PX 10. On March 12, 2012, Respondent's counsel sent Petitioner's counsel a letter via facsimile indicating Petitioner was to report to work at 7:00 AM the following day. PX 11.

Petitioner testified he received no temporary total disability benefits after March 7, 2012. T. 97. He reported to work on March 13, 2012, as directed. He was again assigned to quality assurance at an hourly rate of $23.53 and with a guarantee of 42.5 hours per week. T. 98.

Petitioner testified that, on March 13, 2012, he was required to perform heat taping. When he attempted to perform this task, he again felt his wrist pop. He recalled Jared Warrick, a co-worker and a foreman, either Ron Stidman or Ricky (whose last name he could not recall), being present when his wrist popped. T. 98-99. These individuals were present for the express purpose of watching him perform the heat taping. T. 99. After his wrist popped, he experienced swelling and pain. He reported this to the foreman. At the foreman's direction, he then went to the QC office, where he subsequently met with Jared Warrick and Teresa Grilli.

Petitioner testified that Warrick and Grilli did not allow him to go to the company clinic on this occasion. They told him it was a "continuance of an old injury." T. 100-101. Using his own insurance, he went to Alexian Brothers Corporate Health that day. He received a splint and was released to work with no use of the right hand "until cleared by hand specialist." T. 100-101. Petitioner testified that Respondent did not offer him work within these restrictions. T. 101.

Petitioner returned to Dr. Wiedrich on March 19, 2012. T. 101. The doctor's note of that date reflects that Petitioner reported experiencing pain and popping in his right wrist the first day he attempted to resume regular duty. The doctor also noted that Petitioner complained of significant swelling and ecchymosis about the wrist.

On examination, Dr. Wiedrich noted no visible ecchymosis, no crepitation with motion and "no change in the overall swelling of the wrist from prior visits." He indicated that, "with loading and shucking of the wrist," there was "a slight give and pop consistent with [Petitioner's] descriptions of popping." He indicated this was "coming from the area of the radius and capitates due to the congruency of the PRC." He described Petitioner as stable overall. He released Petitioner to work "within the restraints of the FCE." He instructed Petitioner to return to him as needed. Wiedrich Dep Exh 3, pp. 45-46.

Petitioner testified that, on March 19, 2012, he demonstrated the mechanics of heat taping to Dr. Wiedrich at the doctor's request. Petitioner further testified his wrist popped when he simulated this activity. T. 102.

Petitioner testified that Respondent did not offer him work within Dr. Wiedrich's restrictions after March 19, 2012. T. 102.

Petitioner testified that, during this time period, he told Jared Warrick, Teresa Grilli and union representatives he felt he could perform another job at Respondent, namely a janitor position. Respondent did not allow him to perform this position. T. 103.

On May 1, 2012, Dr. Papierski issued an addendum, after reviewing updated records from Dr. Wiedrich along with a Triune job analysis and video dated November 30, 2011. Dr. Papierski noted that the comment section in the job analysis described lifting of no more than 20 pounds but that "the tables themselves actually indicate lifting up to between 26 and 50 pounds occasionally."

Dr. Papierski noted that he had been asked to review this information "with particular attention to the heat taping activity." He indicated there was nothing about Petitioner diagnoses that would preclude him from performing heat taping but conceded Petitioner "may have some symptoms during this kind of activity, as well as other activities utilizing the right hand." Papierski Dep Exh 4.

On May 1, 2012, Edward Rascati, a certified vocational rehabilitation counselor who has operated EJR Consulting, Inc. since 1996 (Rascati Dep Exh 1), prepared a labor market survey at

Cornacchione's request. T. 113. RX 2 at 4-5. Rascati's report reflects he prepared the survey after learning that Petitioner's attorney "would not allow [a] vocational evaluation." Rascati indicated he reviewed records from Drs. Wiedrich and Papierski, along with various job descriptions, Petitioner's job application and work history and the functional capacity evaluation of November 3, 2011. RX 2 at 5-6.

In his report of May 1, 2012, Rascati noted that Petitioner graduated from Steinmetz High School in 1975 and began working for Respondent in May 1978. Rascati indicated that Petitioner held various positions and underwent various types of training while working for Respondent.

Rascati identified fourteen prospective jobs in his report. Six of these jobs appear to be with/through staffing agencies. Most of the hourly salaries (where identified) range from $10 to $16. One machine operator job paid $19 to $22 per hour, "DOE" [depending on experience.] Rascati indicated the average hourly salary was $13.84. RX 2 at 9. Several of the jobs required lifting of 30 to 35 pounds. One job, a meter reader position with Nicor Gas, required "an extreme amount of physical activity," with the applicants needing to be able to walk between 5 and 10 miles per day "while bending, stretching, kneeling and crawling."

Rascati noted that he could not obtain details regarding some of the jobs. In some instances, he relied on the Dictionary of Occupational Titles, which classifies both slitter operator and embosser jobs as "light," meaning that a maximum of 20 pounds is involved.

Rascati also noted there was "some discrepancy" as to Petitioner's lifting requirements, with Dr. Wiedrich referencing the functional capacity evaluation but simultaneously indicating Petitioner was restricted to lifting less than 20 pounds. PX 16. At his deposition, Rascati testified he attempted to use the lifting restrictions recommended by both Dr. Wiedrich [20 pounds] and Dr. Papierski [30 pounds] in identifying prospective jobs for Petitioner. RX 2 at 17-18.

At his deposition, Rascati opined that Petitioner could potentially secure a job earning up to $22 per hour. Rascati further opined that the lowest end of the salary range was $11 per hour. RX 2 at 9-10.

Under cross-examination, Rascati testified that, if he were to consider only unskilled jobs for Petitioner, those jobs would pay between about $8.25 and $11.00 per hour. RX 2 at 11. Rascati testified he was unaware that Respondent had denied Petitioner's request for vocational rehabilitation prior to his involvement. RX 2 at 13. He agrees with the proposition that a physician needs to review the results of a functional capacity evaluation in order to determine a patient's work restrictions. RX 2 at 16. Rascati indicated he was attempting to maximize Petitioner's 20+ years in manufacturing in preparing the labor market survey. RX 2 at 18. He did not discuss Petitioner's restrictions with any of the prospective employers he contacted. He simply inquired as to those employers' needs. RX 2 at 19. He typically "casts a wide net" when looking for prospective employers, especially when he has no opportunity to

perform a vocational evaluation in person. RX 2 at 21. Cornicchione and Respondent's counsel informed him Petitioner had difficulty performing the "heat taping" aspect of the quality assurance job. Dr. Wiedrich restricted Petitioner from performing heat taping. RX 2 at 22-23. If the prospective jobs he identified in his labor market survey required the type of heat taping Petitioner was required to perform for Respondent, those jobs would not be suitable for Petitioner. RX 2 at 23. If Petitioner contacted all of the prospective employers in the survey and received no responses, that would not prompt him to conclude the jobs were unsuitable. He would need more information as to the nature of Petitioner's contact with the employers. RX 2 at 25.

On May 4, 2012, the Arbitrator conducted a pre-trial at the request of both parties. During this pre-trial, counsel for both parties discussed Petitioner's quality assurance job and, specifically, the heat taping aspect of that job, with the Arbitrator. The Arbitrator did not review any job description or video. The Arbitrator recommended that Petitioner try the job again but use his left hand to perform the heat taping.

On May 9, 2012, Respondent's counsel sent Petitioner's counsel a letter directing Petitioner to report to work at 7:00 AM on May 14, 2012. Petitioner testified he did not report to work at that time because he developed a severe case of food poisoning. He called off work for that reason. T. 105. He reported to work on May 16, 2012 and was assigned to quality assurance. He could not recall whether he actually performed any work on that date. T. 105.

On the afternoon of May 17, 2012, Petitioner sought care at the Emergency Room at Northwest Community Hospital. T. 105. Petitioner indicated he had experienced cramping, diarrhea and vomiting since eating at a buffet the previous Saturday. The Emergency Room physician examined Petitioner, noting some epigastric tenderness. He diagnosed gastroenteritis. He instructed Petitioner to stay off work for three days. He indicated Petitioner could resume working on May 20, 2012, assuming he had not experienced a fever for 24 hours. PX 24.

Petitioner testified he saw his family physician, Dr. Small, on May 21, 23, 25 and 30, 2012. Petitioner testified that Dr. Small kept him off work during this period. T. 106.

Petitioner testified he resumed working on May 31, 2012, a Friday, with the understanding that he was going to attempt to use his non-dominant left hand to perform heat taping. Petitioner testified this attempt did not go well. He lacked the necessary strength and coordination and could not apply the tape properly. Petitioner explained that, when heat tape is not put on correctly, it falls off, requiring the worker to "go back and re-do it on the next stitch that they run through the line when they connect two coils together." T. 107. Petitioner testified he resumed using his right hand to perform the heat taping after he was unable to effectively use his left. As soon as he tried using his right hand, the hand became swollen and painful. T. 108.

Petitioner testified he reported to work on Monday, June 3, 2012, and again tried to use his left hand to perform heat taping. He again encountered difficulty and switched to his right hand, at which point his right wrist became painful and swollen. He managed to work only a few hours. He reported his symptoms to his foreman, Ron Stidham, and then sat in the quality control office at Stidham's direction. T. 109. Later the same day, he met with Jared Warrick, Teresa Grilli and Ralph Rosillo. He testified he told these individuals he tried to do heat taping with his left hand but was unsuccessful. He also reported developing symptoms after switching to his right hand. Teresa Grilli reiterated that he was performing a job he had chosen to perform. She also indicated that, if he could not perform this job, he should go home and call his attorney. T. 110. Petitioner testified he asked whether he would be fired if he went home and was told "no." T. 111. Grilli's E-mail of June 4, 2012 confirms Respondent did not fire Petitioner.

On June 6, 2012, Petitioner returned to Alexian Corporate Health and saw Dr. Reese, who imposed work restrictions. T. 111. Records in PX 13 and PX 15 show that Petitioner complained of right arm pain with associated weakness and tingling on June 6, 2012. Dr. Reese prescribed Naproxen and advised Petitioner to see a hand surgeon and use a wrist spica splint he already had. He released Petitioner to restricted duty with the following restrictions to remain in place "until cleared by hand specialist": limited use of the right hand with splint usage, no tight gripping with the right hand and maximum lifting of 5 pounds with the right hand. There is no evidence indicating Petitioner returned to Dr. Wiedrich or any other "hand specialist" after June 6, 2012. Dr. Wiedrich's last note is dated March 19, 2012.

On June 13, 2012, Petitioner's counsel sent Respondent's counsel a letter asking Respondent to provide Petitioner with work within Dr. Reese's restrictions. PX 13. Petitioner testified that, at no point after June 13, 2012 did Respondent accommodate the restrictions or resume paying benefits. T. 112-113. On July 11, 2012, Petitioner's counsel sent Respondent's counsel a letter indicating that Petitioner would begin a self-directed job search if Respondent did not provide accommodated duty by July 20, 2012. PX 14.

Petitioner testified that, as of about July 20, 2012, he began looking for light duty, after preparing a resume with the help of his daughter. He identified PX 17 as the resume. T. 115. [The Arbitrator notes that the second page of the resume reflects Petitioner obtained a high school diploma in 1975.] He kept logs concerning his job contacts. His daughter prepared most of these logs. PX 17.

Petitioner testified that, in the course of his job search, he contacted all but one of the potential employers listed in Ed Rascati's labor market survey. [He explained he did not contact one employer, a gas company, because the job required extensive crawling.] None of the employers he contacted asked to interview him or made him an offer. T. 114-115.

Petitioner testified that, eventually, he found a job with Sunset Pools and Spas. He began working for this company on about May 12, 2013. The job involved driving a truck to various residences and using a "skimmer" to skim leaves off of swimming pools. He earned

$9.00 per hour. His hours varied. During the busy season, he worked 48 hours per week. T. 117. He continued experiencing pain and swelling in his right wrist and thumb but his symptoms were "not as bad." T. 117.

Petitioner testified that Sunset Pools and Spas laid him off on October 17, 2013. He knew the job was coming to an end prior to the layoff. T. 118.

PX 18 consists of a group of Petitioner's weekly paycheck stubs from Sunset Pools and Spas covering the period May 12, 2013 through September 7, 2013.

Petitioner testified he did not receive any benefits from Respondent during the period he worked for Sunset Pools and Spas. After the layoff, he began looking for work again. He had to stop looking for work on about November 25, 2013 because his daughter, who has an addiction problem, had to be hospitalized and he had to assume custody of his grandchildren. His wife could not take care of their grandchildren because she was working. T. 120. Although his daughter got out of the hospital on December 24, 2013, he had to continue caring for his grandchildren after that date because his daughter is taking mandatory classes at the direction of DCFS. Those classes can take place anytime during the day or evening. At such point that his daughter finishes the classes and regains custody of the children, he will resume looking for work.

Petitioner identified PX 18 as a collection of stubs from the paychecks he received from Sunset Pools and Spas. T. 117-118.

Petitioner testified he met with Ed Pagella, a vocational rehabilitation counselor, at his attorney's request. Following the meeting, which took place on October 18, 2013, Pagella made recommendations and devised a vocational plan. T. 118. [In his report of October 24, 2013, Pagella, a certified vocational counselor, indicated he interviewed Petitioner and reviewed a number of documents, including treatment records and Rascati's labor market survey. He agreed, "in part," with Rascati's opinion that Petitioner could earn an average of $13.84 per hour but went on to say that the average fell "more in line with $12.50 per hour." He recommended that Petitioner complete a "career assessment inventory" to determine his vocational interests" and that Petitioner undergo training in job seeking and interviewing techniques. PX 21.]

Petitioner testified he wants Respondent to initiate vocational rehabilitation under Mr. Pagella's direction. T. 122.

Petitioner identified PX 19 as a group of medical bills from Alexian Brothers Corporate Health, Dr. Wiedrich and Alexian Brothers Medical Group. To his knowledge, these bills remain outstanding. If, in fact, some or all of the bills have been paid, he will not claim them. T. 119.

Under cross-examination, Petitioner testified he recalls experiencing popping in his wrist while performing heat taping as a quality assurance operator on May 23, 2011. He had

performed a quality assurance job for Respondent about 25 or 28 years earlier. T. 126. As of May 23, 2011, he was being trained as he worked. Two individuals, Alex Aguirre and a younger man, were training him. T. 127. Petitioner then acknowledged he could not be sure about the date May 23, 2011. Assuming that is the correct date, he could not recall if he finished his shift that day.

Petitioner initially testified it is "possible" the conference call took place on May 23, 2011. A few minutes later, he indicated he received this call in May or June of 2010, after his first surgery. It was his seniority that afforded him the right to choose among 10 or 11 jobs that had become available due to a plant closure. T. 131. It was Bob Grilli who denied his request to have a day or two to think about his choice. He chose the quality assurance job because it was the highest-paying job of the ones he was offered and because he had performed the job in the past. When he performed this job in the past, the job involved heat taping. T. 132.

Petitioner recalled discussing his concerns about heat taping with the individual who performed his November 3, 2011 functional capacity evaluation. That individual noted his concerns. Dr. Wiedrich took this into consideration in setting work restrictions. T. 133.

Petitioner recalled calling off work on Monday, January 16, 2012, the day he was supposed to return to work. He called off work because he had had no sleep and was sick. T. 133. He believes he returned to work the next day and then spent a week watching safety videos, without actually performing any work. T. 134. When he went to work, he produced whatever restrictions Dr. Wiedrich has imposed. He did not produce restrictions dated November 2011. He believes he was offered short-term disability on January 17, 2012. T. 136. He may have watched safety videos on February 7, 2012. The following day, a Wednesday, he called off work because his wrist pain affected his sleep. T. 138. When he called in, he mentioned the lack of sleep but did not mention his wrist. T. 138. On Thursday, February 9, 2012, he underwent safety training. He cannot recall if he was scheduled to work on Friday, February 10, 2012. On Monday, February 13, 2012, he underwent training on the line and, soon thereafter, began developing pain and swelling in his hand. He went off work, sought care and received temporary total disability benefits through March 12, 2012. He believes he attempted to work on March 13, 2012. He would have started work at 7 AM that day. It "could be" that he complained to Jared Warrick of swelling and tingling in his hand at 7:15 AM on March 13, 2012. It is possible he made this complaint before he attempted to perform any work. T. 141. He returned to Dr. Wiedrich after March 13, 2012 and showed the doctor how he positioned his hand while applying heat tape. When he pushed his hand back, his wrist popped. He told the doctor: "this is what happens when my hand is forced back or my wrist is forced back in the opposite direction." T. 143. After the pre-trial, Respondent arranged for him to return to work to see if he could use his left hand to perform heat taping. T. 144. He called in sick on May 14, 2012. He could not recall whether he also called in sick on May 15, 2012. It is possible he presented to work on May 16, 2012 but left because he was feeling sick. T. 145-146. He lost two weeks of work due to food poisoning but cannot recall the exact dates he was off. He applied for, and received, short-term disability for this period. T. 146-147. He returned to work after this period. He last worked for Respondent on June 4, 2012. That day, he

informed his supervisor he was unable to perform the work. He attended a meeting later that day at which he was told he had to perform the job because he had chosen it. At this meeting, Teresa Grilli ultimately told him to go home and call his attorney. T. 148. He started looking for work at some point thereafter. He cannot recall the date he started his job search. Only the tenth page of his job search records is dated. His daughter's handwriting appears on the first nine pages. His handwriting appears on page ten. That page is dated May 3, 2013. That page shows he contacted Crown Services about a picker/packer job. He cannot recall whether he contacted this business via telephone or the Internet. He could not perform the job because of the weight limit. He learned of the job at Sunset Pools and Spas because a former friend, Scott Bianchi, worked there and told him the job fell within his restrictions. T. 152. When he worked at Sunset Pools and Spas, he drove an automatic van to various sites and used two different poles to skim leaves off pools. The poles were retractable. They extended from 8 to 16 feet. One was made of aluminum and the other was made of fiberglass. He used both hands to extend the pole and skim leaves. He used his thumbs to grasp the pole. He hardly had to move his wrists. He usually moved the pole forward and straight back but sometimes moved it side to side. The poles weighed no more than five pounds. He also had to attach a vacuum to the end of the pole and push it into the water. The vacuum weighed 10 to 15 pounds. The vacuum was used to clean the bottom of the pools. The pools were of varying depths. He had to push against the resistance of the water. T. 157. He probably cleaned about 8 to 10 pools per day. He worked five or six days a week. T. 158.

On redirect, Petitioner testified he physically demonstrated the heat tape activity to Dr. Wiedrich. When he did this, his wrist popped. He did not just verbally describe the job to the doctor. T. 159-160. He injured his wrist performing heat taping on March 13, 2012. T. 160. He did not like the idea of attempting the heat tape application with his left hand but he figured he would give it a try. He "did [his] best." T. 161. He attempted to perform the heat taping several times, per Dr. Papierski, even though he was violating Dr. Wiedrich's restrictions. He made these attempts because he wanted to work. T. 161. Dr. Atluri referred him to Dr. Wiedrich. At no point did he go to a doctor he had chosen completely on his own. T. 162. No one associated with Respondent ever told him why Respondent would not accommodate Dr. Wiedrich's restriction. T. 162. He "probably" started looking for work after July 20, 2012 but he "gets [his] dates mixed up." T. 163-164.

Jared Warrick testified on behalf of Respondent. Warrick testified he is currently the director of quality at Respondent's Elk Grove Village facility. In 2012, he was Respondent's plant manager. It was in May or June of 2010 that Petitioner selected a quality assurance position pursuant to the "effects bargaining agreement." This agreement evolved because one of Respondent's plants was closing. The agreement allowed "senior workers," such as Petitioner, to select available jobs so as to retain their seniority. T. 168. Warrick testified he did not become the plant manager until November 2010 and thus was not involved in the discussion that led to Petitioner choosing the quality assurance job. T. 169.

Warrick testified that Petitioner asked to speak with a manager upon arriving at work on January 17, 2012, following his third surgery. T. 174. Petitioner produced a doctor's note

indicating he could not perform heat taping and had a lifting restriction. The note was "old." Warrick discussed this with Teresa Grilli, Respondent's personnel manager. They decided to allow Petitioner to undergo video safety training so as to afford him time to produce more current documentation. Petitioner was able to provide this documentation. T. 175.

Warrick testified that, on March 13, 2012, he talked with Petitioner at 7:15 AM, before Petitioner had performed any work. He asked Petitioner how he was doing. Petitioner told him he had pain in his hand and did not know why he had been directed to return to work. Petitioner began working. The supervisor on duty watched him work, having been instructed to "make sure that all return to work are watched closely." Warrick also observed Petitioner working with Alex Aguirre. T. 172. Warrick observed Petitioner performing "T bends" and taking measurements. Petitioner did not voice any complaints while Warrick was observing him. T. 173. Later that morning, Petitioner "complained of pain again." Neither Warrick nor any supervisor was able to verify that Petitioner sustained a work injury that day. After Petitioner made the complaint, Warrick met with him and a union representative. Petitioner told them he was unable to perform the job.

Warrick, along with the Arbitrator, counsel and Petitioner, then viewed RX 5, a job video taken by Ruben Luna of Triune on or about November 30, 2011. T. 192. Warrick testified he was present when the video was taken. The video accurately depicts the duties involved in the quality assurance job. Warrick testified that the strips used during heat taping are "very tacky" and can be applied using only mild to light finger pressure. T. 177-178, 184. The tape does not have to line up exactly with the metal strip. Even if it is "slightly skewed," it will give an accurate temperature reading. T. 177-178, 190. Warrick testified he has applied heat tape on many occasions. He has filled in for an absent quality assurance operator on occasion. T. 179. The strips of tape are pre-cut into 2- to 3-inch lengths. The worker has to peel each strip off of a backing. He then places the tape on his radio, watch or gear so as to be ready to apply the tape to the metal strip when it arrives. T. 189. Warrick testified he completely disagrees with Petitioner's testimony that he had to use all of his available force to apply the tape. T. 185. Warrick testified he is right-handed. He has never attempted to use his left hand to apply the tape but he "absolutely" believes a worker could do this. T. 189-190.

Warrick testified that, 44 seconds into the video, Alex Aguirre can be seen opening packages of heat tape. T. 194. About 2 minutes and 27 seconds into the tape, Aguirre can be seen applying the heat tape. About 4 minutes and 23 seconds into the tape, Aguirre can be seen recording measurements. T. 196.

Warrick testified that a quality assurance operator can apply heat tape as little as once and as much as eight times during a single shift. The average is 4 to 5 applications per shift. T. 196-197. Each application involves the placement of two pieces of tape. T. 197. The video shows only one heat tape application. T. 198.

Warrick testified that the quality assurance job does not require any lifting over 20 pounds. Workers performing the job have to handle panels that weigh more than 20 pounds

but they "have a cart that they can use." T. 199. The actual lifting requirement is 25 pounds but Respondent considers that "with a single hand." T. 199.

Warrick testified he appears on the tape at the 10 minute, 45 second point. About four minutes later, Aguirre is again seen on the tape, performing a "T-bend." Warrick testified that a "T-bend" involves folding a coated metal strip over on itself and then taping it in order to check the adhesion of the coating to the strip. T. 201.

Under cross-examination, Warrick testified he began working for Respondent in April 2006, at which point Petitioner was working on the slitter. He cannot say whether Petitioner was a good worker because Petitioner did not report to him. T. 202. He did not review Petitioner's personnel file before taking the stand. T. 203. He became the plant manager in 2010. In preparation for the hearing, he reviewed E-mails involving Petitioner that were sent or received after he became the plant manager. One of Respondent's exhibits contains a timeline of events along with E-mails that substantiate this timeline. T. 208.

Warrick acknowledged that the video does not show all aspects of the quality assurance job. A quality assurance worker has to apply heat tape to two types of coaters: finish and prime. The video shows only a finish coater. The two coaters run at the same speed but there is more space on the finish coater on which to affix the heat tape. The video shows a finish coater operating at an "average" speed. T. 210-211. It also shows the standard type of heat tape. T. 212. It is probably easier to apply the non-standard type, i.e., the high temperature tape, because it is wider and affords "more of a grab." T. 213. The video, which is about 14 minutes long, shows only one heat tape application. The application takes place about 1 minute, 42 seconds into the video. Aguirre performs the application, with the whole process taking just a couple of seconds. T. 213. Aguirre's right hand can be seen traveling backward in a rapid motion as he applies the tape "because he was keeping tempo with the strip" as the strip moved overhead. T. 214. Petitioner would have had to perform the application the same way. Warrick testified he cannot say whether or not Petitioner's wrist popped when he tried to perform the application because he was not present to witness the event. T. 215-216. Warrick testified he could not recall exactly how many times Petitioner tried to perform the quality assurance job. On February 13, 2012, Petitioner made an attempt and reported that his wrist popped. An accident report was completed and Petitioner was sent to the clinic. T. 217. Warrick reviewed RX 14 and testified that this exhibit does not contain any doctor's note releasing Petitioner to heat taping. T. 219. Warrick testified he relies on Respondent's human resources department to review doctors' notes and provide return-to-work dates and restrictions. T. 220. On those occasions when Petitioner attempted to perform the quality assurance job, it was Teresa Grilli who provided the restrictions. Warrick testified he was not made aware that Dr. Wiedrich restricted Petitioner from performing heat taping. T. 222. If he had been aware of this restriction, he would not have put Petitioner back to work in quality assurance. The quality assurance job includes heat taping per the current job description but "there are things that can be done to evaluate." Petitioner was asked to attempt heat taping using his left hand. Petitioner made the attempt but reported this did not work well for him. Warrick testified he (himself) never had to use his non-dominant hand to perform heat taping

because he has no problems with his dominant hand. It would take "a little more time" for him to use his non-dominant hand because he would have to go around the coater. T. 225. On the video, Aguirre can be seen "shuffling" along in order to get to the point where the heat tape comes through. T. 225. The following exchange then occurred:

> "Q. Now, if the metal is running at faster speed, though, he probably would have to hurry down there in order to get there on time, correct?
>
> A: Or he could ask somebody else down there to read the heat tape.
>
> Q: Well, as long as there is somebody else down there to read the heat tape, couldn't that somebody else also be there helping Mr. Mays, helping put the heat tape on for him so he can do the other aspects of his job?
>
> A: That's a possibility, but you need to be able to perform all parts of the function yourself in case nobody else is available.
>
> Q: So if Mr. Mays cannot do the heat taping, then he cannot do that QA job, right?
>
> A: He is not fully qualified, no."

T. 226. Because Petitioner was undergoing "buddy training" when he returned to work in February, March and June 2012, he was being observed by Ron Stidham, the line supervisor, per Respondent protocol. T. 226-227. Stidham was involved in the meetings that were held in connection with Petitioner's attempts to return to work. T. 228. The E-mails in RX 16 would contain any statements Stidham made. T. 228.

Warrick testified that, at 7:15 AM on March 13, 2012, Petitioner told him he did not understand why he was at work that day. Petitioner also said, "look, I'm swollen," gesturing to his hand and wrist. T. 229. Petitioner did not mention Dr. Wiedrich's restriction at that time. T. 229.

Warrick testified that, in January 2012, he asked human resources to provide a more updated work release. It was at this point that Respondent had Petitioner undergo safety training, so as to allow Petitioner to obtain an updated release, which he did. T. 231. Petitioner did not perform any work on January 17, 2012. T. 235.

Warrick testified that, on the video, Aguirre can be seen folding metal over itself once. On some occasions, it is necessary to fold the metal over several times. More force has to be applied when folding the metal four or five times. T. 237. The video does not show Aguirre doing this type of folding. T. 237. Warrick testified that Petitioner told him he was havin

difficulty doing "T bends." It would not be typical for a quality assurance operator to have someone else perform "T bending" because this is an integral task of the job. T. 238.

On redirect, Warrick testified he did not review records from Dr. Wiedrich or Dr. Papierski. Due to privacy laws, he does not review a worker's medical records in his capacity as plant manager. T. 239. Petitioner was not terminated on the last day he worked. T. 240.

Petitioner was recalled to the stand. Petitioner testified that some of the heat tapes used in quality assurance are lightweight, tacky and easy to apply. Those are the tapes that are shown on the video. They are white in color. Other tapes, which are orange and high temperature, are two to three times thicker and much more difficult to apply. These orange tapes were used "all the time." Sometimes there is water on the metal strip. This makes it "impossible" to get the heat tape to adhere. Sometimes there is light powder on the metal strip and you have to "really push" to get the heat tape to stick. T. 246. The prime coater, which is not shown on the video, affords only a couple of feet of room within which to position yourself while trying to apply the heat tape. T. 247. The video shows Aguirre's arm getting "jerked" backward as he applied the heat tape. T. 249. The goal is to get the heat tape positioned in the center of the coil. Some jobs require application of two to three pieces of heat tape at a time. It is "basically impossible" to do this without using both hands. On the occasion when he made an attempt to perform heat taping using his left hand, his body was further under the strip, which made it more difficult for him to extricate himself so he could move to the next position. T. 251. When the metal strip is running 100 feet a minute, it is somewhat easier to apply the heat tape. When the strip is moving at a faster pace, such as 200 feet a minute, it is more difficult. The speed of the strip on the video is not designated. T. 252. The video showed Aguirre performing a "cero T" bend. This is equivalent to folding a piece of paper. Most of the jobs do not call for "cero T" bends. They require folding of thicker pieces of metal. A "4T" bend involves folding a ¼-inch piece of metal, which is difficult to do. You have to stand up, grab the strip and push it down, using your weight. T. 253.

Petitioner testified the video does not accurately depict heat taping or T bends. T. 254.

Under cross-examination, Petitioner acknowledged that the type of heat tape application shown on the video does take place at Respondent's facility but it is not the only type. The strip shown in the video does not look like it is moving very fast. T. 255. On the day he attempted to use his left hand to perform heat taping, he worked for only an hour or two. He is basing his testimony on this attempt. With the prime coater, the strip moves at a height that is a little less than 5 feet. With the finish coater, the height is a little over 5 feet. Regardless of which coater was involved, he had to stoop while performing heat taping. T. 257.

Warrick testified he is aware Petitioner underwent a functional capacity evaluation but he does not recall when the evaluation was performed. T. 233.

As indicated above, Respondent offered into evidence Dr. Papierski's deposition of April 12, 2013. Dr. Papierski acknowledged that Petitioner never described heat taping to him in any

detail. RX 3 at 14. He viewed a video of the quality assurance operator job. RX 3 at 15-16. Based on the video, he saw no need to restrict Petitioner from performing heat taping with his right hand. He did not believe that Petitioner would be inhibited from using his non-dominant left hand to perform heat taping. RX 3 at 18.

Under cross-examination, Dr. Papierski testified a worker may be able to continue a particular work activity despite experiencing symptoms from that activity, so long as the activity does not further damage or aggravate the underlying condition. RX 3 at 22. He conceded that Petitioner might become symptomatic while performing the quality assurance operator job. RX 3 at 23. Based on the measurements he took, Petitioner's right wrist flexion is "about 50 percent of what would be considered normal." RX 3 at 25. In February 2012, he noted tenderness with attempted Finkelstein's maneuvering along with a 5 millimeter gap in "pulp to palm" testing. He had not noted these findings when he examined Petitioner in December 2011. RX 3 at 26-28. These findings were indicative of a decrease in flexibility and range of motion of Petitioner's right thumb. RX 3 at 29. The job description he reviewed did not describe the type of tape Petitioner applied. Nor did it describe the force required to apply the tape. He did not receive any samples of the heat tape. RX 3 at 31-32. He cannot recall what type of motion was needed in order to remove the tape from the dispenser. RX 3 at 37. Heat taping could cause Petitioner to become symptomatic. RX 3 at 38. The person who performed the November 2011 functional capacity evaluation noted that Petitioner grimaced when performing a heat tape simulation. RX 3 at 36-37.

Dr. Papierski testified he did not have enough information to determine the underlying cause of the "popping pain" Petitioner complained of when doing heat taping. RX 3 at 39-40. If a patient of his experienced pain with a particular activity, he might or might not restrict the person from performing that activity. Before imposing a restriction, he would want to know what was going on from an anatomical perspective that was causing a sensation of popping and/or pain. RX 3 at 42. It would be reasonable to restrict a patient from performing that activity while investigating that underlying cause. RX 3 at 42. When he examined Petitioner, there was no indication that Petitioner was feigning or exaggerating his symptoms. RX 3 at 43. It was "potentially" reasonable for Dr. Wiedrich to restrict Petitioner from heat taping. RX 3 at 43.

Dr. Papierski testified that the initial work accident was a competent cause of the right wrist injury Petitioner sustained. The treat Petitioner received was reasonable. Petitioner's injury resulted in some degree of permanent impairment. It was appropriate to restrict Petitioner from full activity. RX 3 at 44.

Dr. Papierski testified that, on average, he devotes about 10 to 15 percent of his time to conducting independent medical examinations. RX 3 at 45, 51. About 90 percent of the examinations he performs are requested by employers or insurance carriers. RX 3 at 51. He and Dr. Atluri worked at the same hand surgery practice but not concurrently. RX 3 at 52. He left that practice because he was in the Air Force reserve and got called to active duty. RX 3 at 53. When scar tissue tears loose, following a surgery such as a de Quervain's release,

symptoms such as bleeding, swelling and pain can occur. These symptoms typically improve over time. RX 3 at 54. It is not typical for additional scar tissue to form during this improvement period. RX 3 at 55. If scar tissue tears loose, it can potentially re-adhere and later pop loose again. RX 3 at 56. This would be rare but not unheard of. RX 3 at 56.

[CONT'D]

Arbitrator's Credibility Assessment – see decision in 12 WC 17346

Arbitrator's Conclusions of Law – 12 WC 17345

What were Petitioner's earnings?

The Arbitrator finds that Petitioner established an average weekly wage of $1,000.03 in 12 WC 17345. No one refuted Petitioner's testimony as to the hourly wage and weekly schedule (i.e., 42.5 hours per week) associated with the quality assurance operator job he was attempting to perform as of his undisputed work accident of February 13, 2012. Arb Exh 2. In fact, Respondent premised much of its defense on Petitioner having "chosen" this job.

Is Petitioner entitled to reasonable and necessary medical expenses?

Petitioner claimed several unpaid medical expenses at the hearing. Respondent claimed that it paid all outstanding balances. Arb Exh 2. Counsel for both parties agreed to confer as to the claimed payments before submitting their proposed decisions. The Arbitrator awards no medical expenses in this case. See the decision in 12 WC 17346.

Is Respondent liable for penalties and fees?

The Arbitrator declines to award penalties and fees in 12 WC 17345. Respondent paid temporary total disability benefits for the period Petitioner was off work following the February 13, 2012 accident, albeit at a lower rate than the rate Petitioner claimed at the hearing. Arb Exh 2.

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

15IWCC0021

MAYS, HAROLD
Employee/Petitioner

Case# 12WC017346

12WC017345
10WC018126

MATERIAL SCIENCE CORPORATION
Employer/Respondent

On 4/3/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.06% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0009 ANESI OZMON RODIN NOVAK KOHEN
JOHN POPELKA
161 N CLARK ST 21ST FL
CHICAGO, IL 60601

0766 HENNESSY & ROACH PC
EDWARD HENNESSY
140 S DEARBORN 7TH FL
CHICAGO, IL 60603

15IWCC0021

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)

Harold Mays
Employee/Petitioner

v.

Material Science Corporation
Employer/Respondent

Case # 12 WC 17346

Consolidated cases: 10 WC 18126
12 WC 17345

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Molly Mason**, Arbitrator of the Commission, in the city of **Chicago**, on **01/21/14 and 01/22/14**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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 **Vocational Rehabilitation**

FINDINGS

On 03/13/12, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

15IWCC002

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

In the year preceding the injury, Petitioner earned $52,001.56*; the average weekly wage was $ 1,000.03.

*annualized

On the date of accident, Petitioner was 54 years of age, *married* with 0 dependent children.

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

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

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $666.69/week for 6/7 weeks commencing 3/14/12 - 3/19/12, as provided in Section 8(b) of the Act. The Arbitrator views Petitioner's right wrist condition as stabilizing as of his last visit to Dr. Wiedrich on March 19, 2012.

Respondent shall pay Petitioner maintenance benefits of $666.69/week for 42 1/7 weeks commencing 7/21/12 – 5/11/13 as provided in Section 8(a) of the Act.

Respondent shall pay Petitioner temporary partial disability benefits of $ (*see chart on p. 32 of attached decision)* for 17 weeks commencing 5/12/13 – 9/7/13 (based on the paycheck stubs in PX 18, which do not reflect any earnings after September 7, 2013) as provided in Section 8(a) of the Act.

Respondent shall pay reasonable and necessary medical services of $127.00 (Dr. Wiedrich, 3/19/12), as provided in Section 8(a) and 8.2 of the Act.

The Arbitrator views Petitioner as a good candidate for vocational rehabilitation but also views Petitioner's claim for vocational rehabilitation as premature. As of the hearing, Petitioner had removed himself from the labor market in order to care for his grandchildren. The Arbitrator orders Respondent, in cooperation with Petitioner and his counsel, and giving consideration to the assessment prepared by Ed Pagella (PX 22), to prepare a vocational assessment pursuant to Rule 7110.10 of the Rules Governing Practice Before the Workers' Compensation Commission, and to update this assessment at four-month intervals until such time as Petitioner re-enters the labor market. Ameritech Services, Inc. v. IWCC, 389 Ill.App.3d 191, 207-8 (1st Dist. 2009).

The Arbitrator declines to award penalties and fees, as requested by Petitioner.

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

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

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

Molly C Mason

Signature of Arbitrator

3/31/14

Date

APR 3 - 2014

Harold Keith Mays v. Material Science Corporation
10 WC 18126, 12 WC 17345-6 (consolidated)

15IWCC0021

Arbitrator's Findings of Fact Relative to All Cases

Petitioner was 55 years old as of the January 21, 2014 hearing. He goes by the name "Keith." He testified he is right-handed. He is 6 feet, 3 inches tall. As of the hearing, he weighed 280 pounds. He testified he has put on about 30 pounds since December 2009. T. 25-26.

In 10 WC 18126, the parties agree Petitioner was injured at work on December 21, 2009. Arb Exh 1. Petitioner testified he worked for Respondent for 31 years before this accident. T. 22. He held a variety of jobs during that period. He was a member of the steelworkers' union throughout his tenure. T. 26. His job titles included quality control worker, skid and box builder, paint room worker, Line 4 pay-off, Line 3 crew chief, slitter assistant, slitter crew chief and embosser helper. T. 26-28.

Petitioner testified he worked as a slitter helper as of December 21, 2009. As a slitter helper, he did packaging and operated a Jeep and forklift. He used a variety of tools, including banders, razor blades and knives. The bander was used to apply bands around large coils of steel or aluminum. These coils weighed between 20 and 45,000 pounds. T. 23-24. He routinely lifted skids that weighed around 50 or 60 pounds. He typically moved these skids by hand "because it was quicker." T. 23. If a skid weighed more than 60 pounds, he used the forklift to move it. He spent about 60 to 70 percent of each workday on his feet and about 30% operating the Jeep. T. 25.

Petitioner testified that, on December 21, 2009, one of his co-workers "backed up [a forklift] really quick," striking a "tilter" in the process. Petitioner described the tilter as a machine that is 8 feet tall and weighs thousands of pounds. The tilter sat on the floor between two large safety plates that were bolted to the ground. When the co-worker struck the tilter, one of the plates broke loose and "swung out," catching the back of Petitioner's feet and swinging Petitioner backward through the air. Petitioner testified his back and right elbow struck the tilter as he swung backward. As he started falling downward, he tried to grab a bar with his right hand but his hand "slipped off." He landed on concrete, striking his right elbow and the right side of his wrist. T. 32.

Petitioner testified he felt pain in his back, right wrist and right arm immediately after the accident. He noticed that his right elbow was bleeding. T. 33.

Petitioner denied injuring his low back prior to December 21, 2009. He had injured his right wrist and hand before that date but those injuries consisted only of cuts. T. 33.

Petitioner testified he saw Dr. McAndrew at Alexian Brothers Corporate Health Services [hereafter "Corporate Health"] the same day he was injured. Respondent sent him to this

facility. T. 34-35. He underwent drug and alcohol testing there. The test results were negative. Dr. McAndrew examined him and sent him to another facility for X-rays. T. 34-35.

The Corporate Health records of December 21, 2009 set forth a consistent account of the work accident. The records reflect that Petitioner primarily complained of his right wrist and hand but also complained of back pain. Petitioner indicated he struck the back of his right wrist. He complained of "throbbing and tingling" in his right hand. PX 1, p. 3. On right wrist examination, Dr. McAndrew noted pain over the snuffbox area, mild swelling and a full range of motion. He also noted the possibility of a foreign body in the thenar area. Right elbow and right wrist X-rays showed no evidence of fracture or dislocation. Right hand X-rays showed no evidence of fracture or dislocation and no definite evidence of a radio-opaque foreign body. PX 1, pp. 10-12. Dr. McAndrew diagnosed contusions of the right wrist, right elbow and back. He prescribed Ibuprofen and ice applications. He released Petitioner to light duty with no lifting over 10 pounds with the right hand, limited gripping/grasping/pinching with the right hand and overall lifting/pushing/pulling limited to 20 pounds. PX 1, p. 6.

Petitioner testified he began performing light duty after December 21, 2009. He wore a splint constantly and "went to work in pain." His wrist "kept getting worse and worse." T. 36.

Petitioner returned to Corporate Health on January 5, 2010 and again saw Dr. McAndrew. T. 36. The doctor noted that Petitioner was still experiencing back and right elbow soreness but primarily complained of right wrist pain and numbness in his fingers.

Dr. McAndrew re-examined Petitioner and prescribed new right wrist X-rays with navicular views. He refilled the Ibuprofen and provided Petitioner with a wrist splint. He released Petitioner to light duty with lifting/pushing/pulling with the right arm limited to 10 to 20 pounds, no climbing, limited gripping/grasping with the right hand and no pounding or hammering with the right hand. He stressed the importance of adhering to the restrictions and instructed Petitioner to follow up on January 13, 2010. He indicated he "left VM for T. Grilli re: importance of follow RTW." PX 1, p. 18.

The new right wrist X-rays, performed on January 5, 2010, showed "mild degenerative type subchondral cysts" but no definite evidence of acute fracture or dislocation. The radiologist indicated that an MRI should be given consideration "given the history of persistent pain." PX 1, p. 19.

Petitioner returned to Corporate Health on January 13, 2010, as directed, and again saw Dr. McAndrew. The doctor noted that Petitioner was wearing his wrist splint and that he complained of wrist pain that worsened with use and episodes of numbness in the first, second and third fingers of his right hand.

On right wrist examination, Dr. McAndrew noted pain over the distal radius, no swelling and a full range of motion. He described Tinel's and Phalen's testing as negative. PX 1, p. 23.

Dr. McAndrew again diagnosed a right wrist contusion. He described Petitioner's back and elbow problems as "resolved." He recommended that Petitioner see a hand specialist. He instructed Petitioner to continue taking the Ibuprofen and wearing the splint. He released Petitioner to light duty with right hand lifting/carrying limited to 15 pounds and limited use of the right hand and arm. PX 1, pp. 25-26.

Petitioner saw Dr. Atluri, a hand surgeon, on January 20, 2010. Dr. Atluri sent a report to Teresa Grilli of Respondent the same day. The report sets forth a consistent account of the December 21, 2009 work accident. Dr. Atluri noted that Petitioner's back and elbow symptoms had resolved but that he was still experiencing pain in his right hand and wrist, especially at the base of the thumb, along with occasional tingling shooting into the dorsal hand and thumb. He also noted that Petitioner denied any prior right hand problems.

On right wrist examination, Dr. Atluri noted limited range of motion, swelling with mild tenderness over the scapholunate interval, tenderness at the anatomic snuff box and first dorsal extensor compartment, maximum tenderness at the thumb CMC joint, tenderness at the distal pole of the scaphoid, negative Finkelstein's testing, positive thumb CMC grind, pain but no clunking with Watson's testing and "nearly full digital motion but [inability] to make a tight fist due to pain." PX 1, p. 34.

Dr. Atluri obtained right wrist X-rays, including scaphoid views. He indicated the films showed no obvious fractures or carpal mal-alignment.

Dr. Atluri's impression was "right wrist derangement." He suspected a ligamentous injury and could not rule out an occult scaphoid fracture. He prescribed a right wrist MRI and converted Petitioner to a forearm-based thumb spica splint. PX 1, pp. 31-32. He instructed Petitioner to wear this splint at home and work. He released Petitioner to light duty with lifting/carrying/pushing/pulling limited to 5 pounds, limited gripping/grasping with the right hand and splint usage. He instructed Petitioner to return after the MRI. PX 1, pp. 33, 35.

The right wrist MRI, performed without contrast on January 27, 2010, showed a "small joint effusion dorsal to the distal scaphoid compatible with mild synovitis." The radiologist indicated that the triangular fibrocartilage and scapholunate ligament appeared to be intact. He also indicated that the MRI had to be performed on a 0.3 T MRI "due to claustrophobia." PX 1, pp. 147-148.

Petitioner returned to Dr. Atluri on February 3, 2010. The doctor described the MRI as a "poor quality study." He described the MRI as showing no fractures or evidence of Kienbock's disease. He indicated the MRI was "otherwise non-diagnostic." He also indicated he was "still concerned about a possible ligament injury" but recommended another six weeks of conservative care. He stated he would consider performing an arthroscopy if Petitioner remained symptomatic at that point. He prescribed occupational therapy and continued the previous work restrictions. PX 1, pp. 36-39.

At the next visit, on March 17, 2010, Dr. Atluri noted that Petitioner continued to complain of right wrist pain and also complained of "increased numbness in the thumb, index and middle fingers."

On examination, Dr. Atluri noted tenderness at the thumb CMC joint, positive thumb CMC grind with some crepitus and positive digital compression testing over the carpal tunnel. He prescribed an EMG and continued the previous work restrictions. T. 40. PX 1, pp. 40-43

Dr. Barbara Heller, a physiatrist, performed EMG/NCV testing of Petitioner at Occspecialists on April 1, 2010. Dr. Heller interpreted the EMG/NCV as providing "electrodiagnostic evidence of a moderate sensory and motor primarily demyelinating carpal tunnel syndrome or median nerve entrapment neuropathy at the right wrist. PX 2, p. 6.

Petitioner returned to Dr. Atluri on April 7, 2010 and complained of increased numbness and tingling in his right hand. The doctor reviewed the EMG/NCV results. On examination, he noted a positive Tinel's over the carpal tunnel and over the dorsal radial sensory nerve with tenderness along the dorsal radial aspect of the wrist and distal forearm. He also noted a positive Watson, although "no significant tenderness over the dorsal wrist."

Dr. Atluri's impression was: carpal tunnel syndrome, Wartenberg syndrome and right wrist derangement. He indicated he still suspected a ligamentous injury. He noted that Petitioner had undergone four months of conservative care without resolution of his symptoms. He discussed various surgical options, including a carpal tunnel release and dorsal radial sensory nerve decompression. He noted that Petitioner agreed to undergo surgery. He continued the previous work restrictions. PX 1, pp. 44-48.

On May 3, 2010, Dr. Atluri operated on Petitioner's right wrist at Alexian Brothers Medical Center. T. 41. The surgery consisted of a right wrist arthroscopy with debridement of a TFCC tear, an open carpal tunnel release, a dorsal radial sensory nerve neurolysis and an open radial tunnel release. In his operative report, Dr. Atluri noted that the scapholunate ligament was "bulging" but not torn and that the TFCC "had a radial-sided tear with irregular flaps." He also noted that the dorsal radial sensory nerve was "healthy in appearance distally" but "demyelinated and flattened along the edge of the brachioradialis tendon." Proximal dissection revealed that the nerve was dymyelinated "even beyond the brachioradialis tendon." PX 3, pp. 42-44. PX 3. Following the surgery, Dr. Atluri instructed Petitioner to stay off work and avoid using his right hand. PX 3, p. 12.

Petitioner testified he began losing time from work as of the May 3, 2010 surgery. He initially received temporary total disability benefits. T. 41.

Petitioner testified he underwent occupational therapy at Alexian Occupational Clinic from May 10, 2010 through August 19, 2010. T. 41. He continued seeing Dr. Atluri during this time. T. 42.

On May 26, 2010, Dr. Atluri noted that Petitioner described his finger symptoms as improved but still complained of pain in the forearm and hand. On examination, the doctor noted that Petitioner could not make a fist. He also noted swelling and diffuse tenderness throughout the hand and forearm. He recommended that Petitioner continue therapy. He released Petitioner to work with no use of the right hand or arm. PX 1, pp. 52-56.

Petitioner testified he obtained some benefit from the surgery. Petitioner also testified that Respondent was unable to accommodate Dr. Atluri's restriction of no use of the right hand or arm. T. 42-43.

On June 23, 2010, Dr. Atluri noted that Petitioner's forearm pain had diminished but that he was still experiencing pain in the wrist, "particularly at the radial aspect of the wrist along with some tingling at the dorsal thumb." He prescribed additional therapy and continued the previous work restriction. PX 1, pp. 59.

On August 4, 2010, Dr. Atluri noted that Petitioner had plateaued in therapy and reported being unable to progress past 3 pounds due to wrist pain.

On examination, the doctor noted tenderness at the dorsal wrist near the scapholunate interval, a positive TFC grind with some crepitus, mild tenderness over the first extensor compartment, a negative Finkelstein's test, pain with wrist motion past 30 degrees of extension and 55 degrees of flexion, weak grip strength and pain with forceful gripping.

Dr. Atluri advised Petitioner that only a total wrist arthrodesis would completely eliminate Petitioner's pain. He viewed a limited arthrodesis as a better option, function-wise. He also viewed a proximal row carpectomy as a reasonable option. He indicated Petitioner might require permanent restrictions postoperatively. T. 44. He discontinued therapy (T. 43), continued the previous restriction and noted that Petitioner planned to return in two weeks. PX 1, pp. 62-65.

In his note of August 18, 2010, Dr. Atluri indicated that Petitioner opted for a proximal row carpectomy. He also indicated he warned Petitioner that this surgery would not eliminate all of the symptoms. He continued the previous restriction. PX 1, pp. 66-70.

Petitioner testified he decided to undergo surgery as of August 18, 2010 but told Dr. Atluri he wanted to obtain a second opinion concerning his surgical options. T. 44-45. He called the workers' compensation carrier and asked if there was a doctor they could recommend. They recommended he see Dr. Papierski. T. 44.

On September 29, 2010, Petitioner returned to Dr. Atluri. Petitioner reported that he was still awaiting surgical authorization and that he was scheduled to see Dr. Papierski for an IME. On examination, Dr. Atluri noted pain with range of motion and "positive Watson's tenderness radially and dorsally." He continued the previous restriction. PX 1, pp. 72-75.

At Respondent's request, Petitioner saw Dr. Papierski for a Section 12 examination on September 30, 2010. Dr. Papierski is a board certified orthopedic surgeon with added qualification in hand surgery. He is also a certified medical examiner. RX 3 at 4-5. Papierski Dep Exh 1.

Dr. Papierski's report concerning his September 30, 2010 examination is not in evidence. At his April 12, 2013 deposition, Dr. Papierski testified he reviewed Dr. Atluri's note of August 18, 2010 in connection with that examination. He viewed Dr. Atluri's various surgical recommendations as reasonable. His own recommendation "included trying to isolate where pain in [Petitioner's] wrist might be coming from," via injecting local anesthetic into various areas of the wrist "to see which areas of the wrist would be getting relief of pain." He also felt that Petitioner's condition "would probably merit additional treatment." He believed consideration could be given to an extensor tendon compartment release, an arthroscopic resection of the distal ulna or proximal hamate or a radioscapholunate arthrodesis, "another type of limited fusion." RX 3 at 7-8.

On October 20, 2010, Petitioner discussed Dr. Papierski's findings and recommendations with Dr. Atluri. Dr. Atluri noted that Petitioner indicated he was interested in surgery rather than additional conservative care. Petitioner again opted to undergo a proximal row carpectomy. Dr. Atluri continued the previous restriction. PX 1, pp. 76-80.

On November 19, 2010, Dr. Atluri performed a right wrist proximal row carpectomy and a right wrist posterior interosseous neurectomy at Alexian Brothers Medical Center. PX 3. Post-operative X-rays revealed "good carpal alignment with post-surgical changes." They also revealed that the capitates was "well seated in the lunate fossa." PX 3, pp. 80-81. Following the surgery, Dr. Atluri instructed Petitioner to stay off work and avoid using his right hand and arm. PX 3, p. 67.

Petitioner testified that, at some point after the November 19, 2010 surgery, he noticed he was still experiencing pain in his right thumb and wrist. T. 47.

On November 24, 2010, Petitioner began a course of therapy at Alexian Occupational Clinic. On that date, the evaluating therapist noted that Petitioner's right hand and wrist "presented with severe pitting edema." The therapist utilized massage techniques in an effort to reduce this edema. PX 1, p. 139.

Petitioner testified that, on November 30, 2010, he was performing therapy when he noticed and heard a popping noise in his right wrist and thumb. He had never experienced this before. T. 48. Within half an hour of hearing the noise, he began experiencing swelling. T. 48-49. The therapist applied ice to the affected area. T. 49.

The following day, December 1, 2010, Dr. Atluri noted that Petitioner complained of a "pop" while exercising. The doctor obtained right wrist X-rays. He described the X-rays as looking okay. He instructed Petitioner to continue wearing the splint and attending therapy.

On December 29, 2010, Petitioner returned to Dr. Atluri. On examination, Dr. Atluri noted significantly less swelling but very reduced grip strength. He indicated Petitioner could flex his fingers to mid-palm but could not make a fist. He instructed Petitioner to wean off the splint and continue therapy. He continued the previous restriction. PX 1, pp. 84-87.

On January 26, 2011, Dr. Atluri injected cortisone into Petitioner's right thumb CMC joint. He directed Petitioner to wear a thumb CMC joint splint at night and continue therapy. He imposed new restrictions of no lifting/carrying/pushing/pulling, limited grasping/pinching and splint usage. PX 1, pp. 88-93.

At the next visit, on February 23, 2011, Petitioner reported no improvement secondary to the injection. He continued to complain of pain at the base of his thumb. Dr. Atluri recommended that Petitioner continue therapy for another month and then potentially transition to work conditioning. He continued the previous restrictions. PX 1, pp. 94-99.

On April 5, 2011, Dr. Atluri recommended that Petitioner transition to work conditioning. PX 1.

On April 7, 2011, Petitioner underwent a work conditioning evaluation at AthletiCo. The evaluating therapist recorded a history of the December 21, 2009 injury and subsequent care. The therapist also noted that Petitioner was subject to work restrictions, that no light duty was available and that Petitioner was "looking to return to work with quality assurance duties." Petitioner reported a pain rating of 1-2/10 at rest that increased to 7-8/10 "during forceful gripping and lifting activities." On examination, the therapist noted grip strength of 60 pounds on the right (versus 100 on the left), three-point pinch strength of 16 pounds on the right (versus 26 on the left) and lateral pinch strength of 20 pounds on the right (versus 29 on the left). PX 5.

Petitioner returned to Dr. Atluri on May 3, 2011. The doctor noted that Petitioner was making good progress in work conditioning. He indicated he had been provided with a written description of a job that required lifting up to 25 pounds. He released Petitioner to this job on a part-time basis for the next two weeks, indicating that Petitioner should continue work conditioning while performing the new job four hours per day. He indicated Petitioner could resume full duty after undergoing work conditioning for two weeks. PX 1, pp. 101.

Petitioner testified that work conditioning was beneficial in terms of increasing his overall activity level but it did not help his wrist or thumb. He continued experiencing swelling and pain. T. 53-54. A work conditioning note dated May 11, 2011 reflects Petitioner continued to complain of thumb pain and planned to see another surgeon in about a month. The same note reflects Petitioner reported a "pop" in his shoulder while performing "lat pull-downs" and cancelled a session scheduled for the following day due to shoulder pain. PX 5, pp. 56-57.

On May 12, 2011, Marianne Cornacchione, a claim supervisor affiliated with CCMSI [hereafter "Cornacchione"], sent the following note to Petitioner's counsel via facsimile:

> "Mr. Mays has been returned to work full duty as of Monday 5/23/11. Please see attached and advise your client."

PX 6, p. 1. Attached to this note is a letter bearing the same date from Cornacchione to Petitioner's counsel referencing and attaching Dr. Atluri's note of May 3, 2011. PX 6, p. 3. In the letter, Cornacchione indicated she authorized the additional two weeks of work conditioning the doctor prescribed on May 3, 2011. She further indicated that, per Dr. Atluri, Petitioner would be capable of full duty once the two weeks had been completed, that she would continue paying temporary total disability benefits through May 22, 2011 and that Respondent had scheduled Petitioner to return to work on Monday, May 23, 2011. PX 6, p. 2.

A document in the AthletiCo records (PX 5) reflects that Petitioner attended work conditioning through May 12, 2011 and was subsequently discharged from work conditioning based on a case manager's report that he resumed full duty on May 16, 2011. PX 5, p. 59. Petitioner did not testify to resuming full duty on that date. He testified Dr. Atluri never released him to full duty. T. 54-55. He further testified he began performing a quality assurance job at Respondent on May 23, 2011. On direct examination, he testified he started this job after participating in a speaker phone conference call with Bob and Teresa Grilli of Respondent and some union officials. He testified he did not anticipate receiving this call. During the call, he was told that the Respondent plant where he had previously worked had closed and that he had to choose a job to perform "at the next plant." The callers presented him with ten or eleven jobs, including a quality assurance job, to choose from. Petitioner testified he asked the callers whether he could have a day or two to think about his choice but was told he had to make a decision on the spot. He chose the quality assurance job because it paid the most and because he had worked in quality assurance for Respondent many years earlier. T. 59.

Petitioner testified that, when he presented to the quality assurance job on May 23, 2011, he was told he "had to learn how to do the job in ten days." An individual named Alex Aguirre trained him. T. 59-60.

Petitioner testified that one of his duties in the quality assurance job was to apply "heat tape" to the bottom of a metal strip that moved along an elevated line. He was required to apply heat tape the first day he worked in quality assurance. T. 60-61. Petitioner described heat tape as a "four-inch sticky piece of tape" that reads the temperature of metal "once it goes into ovens." T. 61. The line along which the metal strip moved was about 4 to 4 ½ feet above ground level. Petitioner testified he had to "duck a couple of feet to get under the strip." The rate at which the strip moved along the line varied, depending on the job. Petitioner testified the strip could move as slowly as 100 feet per minute to 260-300 feet per minute. T. 61. Petitioner indicated he had to use his thumb and index finger in order to affix the heat tape

to the moving metal strip. He had to "really push down" on the heat tape in order to make sure it stuck to the metal strip. T. 63-64. Petitioner would position himself under the line with his right elbow at a 90 degree angle away from his body and his right thumb pointing up. When the moving metal strip got close to him, and was almost overhead, he would forcefully push the heat tape onto the bottom of the strip and then keep pushing as the strip continue moving. His right thumb would move backward in the process. T. 64.

Petitioner testified that, on his first attempt at applying heat tape on the morning of May 23, 2011, he felt his right wrist pop and experienced pain in his right wrist and thumb. T. 65. He moved out from underneath the line and tried to shake off his pain, "hoping it was nothing major." He then ran down to the finish coater in order to apply another piece of heat tape. When he applied this piece, his right wrist "really popped." Petitioner testified he immediately reported this to his foreman. The foreman told him to sit down for a few minutes. He sat down but "the swelling started almost immediately" and his pain increased. T. 66. He did not resume working that day. T. 66-67.

Petitioner testified he was off work from May 24, 2011 through January 6, 2012. He received temporary total disability benefits during this period. T. 67.

On May 26, 2011, Petitioner returned to Dr. Atluri. The doctor noted that Petitioner had started a new light duty job but was complaining of increased thumb pain secondary to a number of work activities. Petitioner reported that the new job position required him to "apply pressure with his thumb and perform some pinching maneuvers." On examination, Dr. Atluri noted tenderness at the thumb CMC joint and a little bit of intermittent clicking with CMC grind.

Dr. Atluri obtained new X-rays. He interpreted the films as showing mild arthrosis at the thumb CMC joint and post-surgical changes.

Dr. Atluri indicated "it does not appear as if [Petitioner] can perform his light duty work due to his thumb pain." He did not feel the thumb arthritis warranted additional surgery. He noted that Petitioner "does feel better in the splint but states he cannot perform his necessary work duties with the splint in place."

Dr. Atluri advised Petitioner to use the splint for symptom control. He noted Petitioner was seeing Dr. Wiedrich for a second opinion. He indicated he thought this was an "excellent idea." He recommended that Petitioner return to him after seeing Dr. Wiedrich. He released Petitioner to restricted duty with splint usage. PX 1, pp. 102-103. PX 6.

Petitioner testified that, on May 26, 2011, he asked Dr. Atluri who he should see for his thumb after Dr. Atluri told him he was not a thumb expert and "couldn't do anything for the thumb area." According to Petitioner, it was at this point in the conversation that Dr. Wiedrich's name came up. Dr. Atluri recommended he see Dr. Wiedrich. T. 69.

Petitioner first saw Dr. Wiedrich on July 13, 2011. Dr. Wiedrich is a fellowship-trained hand surgeon. He achieved board certification in plastic surgery in 1994 and added qualification in hand surgery the following year. PX 4 at 6. He has been an assistant professor at Northwestern University's medical school since 1992. Wiedrich Dep Exh 2.

Dr. Wiedrich's initial note of July 13, 2011 reflects that "no data" was available as to the identity of the referring physician.

Dr. Wiedrich's note sets forth a consistent history of the December 21, 2009 work accident and subsequent care. He indicated that Petitioner complained of right thumb pain, which prevented him from working, and difficulty with right wrist extension. On range of motion testing, he noted dorsal flexion/proximal flexion of 30/55 in the right wrist and 65/65 in the left wrist and radial deviation/ulnar deviation of 5/20 in the right wrist and 20/30 in the left wrist. On right wrist examination, he noted mild dorsal wrist swelling and well-healed incisions about the wrist and forearm. He also noted radial styloid tenderness and mild tenderness of the first CMC joint. He obtained Fluoro Scan images and interpreted them as showing "evidence of radial trapezoid abutment." He indicated Petitioner "would benefit from a radial styloidectomy." He described his "plan" as follows: "IME report." He completed a disability certificate releasing Petitioner to restricted duty with limited use of the right hand, specifically "no forceful lifting and radial deviation." He indicated Petitioner should be off work if these restrictions could not be met. Wiedrich Dep Exh 3, p. 7.

Dr. Wiedrich wrote to Cornacchione and the nurse case manager, Gloria Torres, R.N., the same day, enclosing his note, describing Petitioner's work restrictions and indicating he anticipated Petitioner would reach maximum medical improvement three months after a radial styloidectomy. Wiedrich Dep Exh 3, p. 8.

On August 19, 2011, Dr. Wiedrich operated on Petitioner's right wrist at Northwestern Memorial Hospital. The surgery consisted of a radial styloidectomy and a release of the first dorsal compartment. Wiedrich Dep Exh 3, pp. 10-11.

Petitioner testified he did not notice much improvement following the surgery. He "still had the pain." T. 70.

Petitioner followed up with Dr. Wiedrich three days postoperatively. The doctor described Petitioner's radial nerve function as good. He placed Petitioner in a short arm thumb spica splint and instructed him to start occupational therapy and return in ten days. He released Petitioner to work with no use of the right hand. Wiedrich Dep Exh 3, pp. 12-15. Petitioner testified Respondent did not accommodate this restriction. T. 70-71.

At the next visit, on September 1, 2011, Petitioner complained to Dr. Wiedrich of pain with radial/ulnar deviation. He indicated he was wearing the splint most of the time. The doctor prescribed therapy and continued the previous work restriction. Wiedrich Dep Exh 3, pp. 16-19.

Petitioner testified he participated in therapy at Athletico through November 3, 2011. The therapy did not help much. He continued to experience pain and swelling. He had to apply ice to his right hand after each therapy session. T. 71-72.

On October 4, 2011, Dr. Wiedrich noted that Petitioner was still complaining of wrist pain and reported "marginal improvement." T. 72. On right wrist examination, the doctor noted diffuse tenderness, no significant swelling, no crepitus and a positive Tinel sign down the length of the entire superficial radial nerve. He obtained X-rays, which showed evidence of the surgeries and no significant arthritis. He prescribed four more weeks of therapy, followed by a functional capacity evaluation. He continued the previous work restriction. Wiedrich Dep Exh 3, pp. 20-25.

Petitioner underwent a functional capacity evaluation at AthletiCo on November 3, 2011. In his report of that date, the evaluator described Petitioner as cooperative throughout the evaluation. He described Petitioner's effort as variable and noted "minor inconsistency to the reliability and accuracy of [Petitioner's] reports of pain and disability." He noted "maximum voluntary effort" with Jamar grip strength testing. Petitioner's grip strength was 60.67 pounds on the right versus 92 on the left. Petitioner successfully completed a pegboard manual dexterity test but exhibited signs of discomfort during this test. Based on both a DOT job description and a job description provided by Respondent, the evaluator found Petitioner capable of "returning to his pre-injury job demands as a quality assurance analyst." He noted, however, that Petitioner described heat tape application as his "biggest concern" with the target job position. He indicated he was "unable to test specific work tasks related to application of heat tape" but that Petitioner was able to participate in "workflow simulation" twice. He indicated that, during this simulation, Petitioner reported right wrist fatigue and "demonstrated signs of discomfort." Near the end of his report, he stated that Petitioner might benefit from a pain program and from avoiding certain tasks such as heat tape application. He indicated that the final determination as to work restrictions should be made by Petitioner's physician. Wiedrich Dep Exh 4, pp. 39-40.

Petitioner testified he discussed the mechanics of heat tape application with the therapist who conducted the functional capacity evaluation. T. 73. Following the evaluation, his wrist pain and swelling increased. He informed Dr. Wiedrich of this. T. 74.

Petitioner returned to Dr. Wiedrich on November 9, 2011. The doctor noted that Petitioner had recently undergone a functional capacity evaluation and experienced significant pain and swelling for several days thereafter. The doctor's examination findings were unchanged. He reviewed the functional capacity evaluation with Petitioner and released Petitioner to restricted duty with lifting less than 20 pounds, no heat taping and frequent breaks. Wiedrich Dep Exh 3, pp. 28-29.

At the next visit, on December 5, 2011, Dr. Wiedrich noted that Petitioner was still experiencing pain and had not resumed working. On examination, he again noted a positive

Tinel's sign over the radial nerve and diffuse pain over the right wrist. He indicated Petitioner "should work within the confines of his restrictions or he could undergo vocational rehabilitation." T. 75. He instructed Petitioner to return to him in three months. Wiedrich Dep Exh 3, p. 30. He continued the previous work restrictions. Wiedrich Dep Exh 3, p. 31.

At Respondent's request, Dr. Papierski re-examined Petitioner on December 27, 2011. In his report of that date, Dr. Papierski noted that Petitioner complained of "mostly continuous pain with occasional sharp shooting pains in the dorsal, radial and ulnar aspects of the right wrist." He also noted that Petitioner was currently off work due to a 20-pound lifting restriction.

On right wrist re-examination, Dr. Papierski noted radial and dorsal tenderness, flexion of 35 degrees (versus 80 on the left), extension of 50 degrees (versus 80 on the left), 4/5 flexion and extension strength (versus 5/5 on the left) and tenderness with Finkelstein's testing. At his deposition, Dr. Papierski testified that Petitioner's right wrist flexion and extension measurements were "pretty close to the expected range of motion of someone who has had a proximal row carpectomy." He indicated that a proximal row carpectomy is a form of arthroplasty. It preserves some wrist range of motion while removing the arthritic portions of the wrist joint. RX 3 at 10. On right hand re-examination, Dr. Papierski noted tenderness with CMC range of motion.

Dr. Papierski obtained AP and hyper-pronated right wrist X-rays. He interpreted the films as showing absence of the proximal row of bones of the wrist "with the capitates settled nicely in the lunate facet of the distal radius." He saw "no further evidence of first carpometacarpal joint degenerative change."

Dr. Papierski indicated that he reviewed two different descriptions of the quality assurance operator position. The first, a Triune analysis performed for Respondent, indicated that the heaviest weight lifted or carried ranged from 15 to 20 pounds but also included an "activity table of information" indicating that 20 to 50 pounds had to be lifted in less than an hour. The second, a "revised" description, indicated that physical effort was "up to 30 pounds."

Citing the recent functional capacity evaluation, Dr. Papierski found Petitioner capable of resuming work as a quality assurance operator. He indicated that, while "there may be ongoing symptoms," there was nothing that would otherwise prevent Petitioner from resuming the job.

Dr. Papierski indicated that Petitioner would reach maximum medical improvement sometime in January 2012, six months after his most recent surgery. Papierski Dep Exh 2.

Petitioner testified that Dr. Papierski found him capable of returning to work as a quality assurance operator. T. 76.

On January 9, 2012, Cornacchione sent Petitioner's counsel a letter indicating that Petitioner was scheduled to resume full duty on Monday, January 18, 2012. T. 76-77. PX 7.

Petitioner testified he resumed his quality assurance job on about January 16, 2012. This job paid $23.53 per hour, more than his previous job. He was guaranteed 42.5 hours of work per week. He received the extra hours beyond the standard 40 per week in exchange for working through lunch instead of taking a half-hour lunch break. T. 78.

Petitioner testified he did not undergo any additional training before he started working on January 16, 2012. His duties were the same as those he had attempted to perform on May 23, 2011. T. 78. As soon as he started heat taping on January 16, 2012, he felt his right wrist give way again. Ron Stidham was his foreman at that time. Stidham was the foreman assigned to Line 4, the line to which Petitioner was assigned. Stidham answered to Jared Warrick. Petitioner testified he was supposed to report any injury or concern to Stidham as of January 16, 2012. T. 81. He notified Stidham of his wrist problem. A third individual was also present during his conversation with Stidham. This person was either Alex Aguirre or a younger quality control employee whose name Petitioner could not recall. T. 79. Over Respondent's objection, Petitioner testified that, after he told Stidham his wrist had popped again, Stidham said, "well, there is nothing I can do – go up front and sit in the QC office until we report to Jared." T. 82. Petitioner went to the office. Later that day he met with Jared Warrick, Teresa Grilli and Ralph Rosillo, a union representative. Petitioner testified that Warrick is Respondent's plant manager and Grilli is Respondent's personnel manager. T. 83-84. During the meeting, he explained how he had re-injured his wrist. In response, Grilli said there was nothing she could do, that Petitioner was performing a job he had selected and that if he was not able to perform this job, he should go home and call his attorney. T. 84.

Petitioner testified he was off work from January 18, 2012 through February 6, 2012. He indicated he did not receive temporary total disability benefits during this interval. T. 85. He resumed working in quality assurance, at the same rate of pay, on February 7, 2012. During the first week of work, he watched videos of safety-related classes he had missed while he was off work. He did not experience any physical problems while sitting and watching the videos. T. 85-86.

Petitioner testified his right wrist "popped again" on February 13, 2012, immediately after he started applying heat tape. He reported this to Ron Stidham. At Stidham's direction, he went to the QC office and waited. Later the same day, he met with Jared Warrick, Teresa Grilli, Ralph Rosillo and possibly Rich Hart, another union representative. During this meeting, he was told his injury was "ongoing" and he "should just contact [his] attorney." T. 87.

Petitioner testified that, at Respondent's direction, he went to Alexian Brothers Corporate Health on February 13, 2012. He underwent drug and alcohol tests at this facility. The test results were negative. PX 1, pp. 119-120. He also saw Dr. Baksinski, who examined him, recommended he return to Dr. Wiedrich and released him to light duty with splint usage and no use of the right hand "until cleared by orthopedic surgeon." PX 1, p. 122.

The February 13, 2012 records from Alexian Brothers Corporate Health reflect that Petitioner reported experiencing a pop in his right wrist while applying heat tape that morning. The records also reflect that Petitioner complained of throbbing pain radiating to his right thumb. Dr. Baksinski examined Petitioner and ordered right wrist X-rays. The X-rays showed post-surgical changes and "no significant change" since the previous X-rays of December 1, 2010. PX 1, p. 112. Dr. Baksinski diagnosed a wrist sprain/strain. She dispensed a wrist splint and instructed Petitioner to wear the splint at work and home. She also prescribed Ibuprofen. She noted Petitioner planned to follow up "with ortho specialist of his choice." She released Petitioner to work with use of the splint and no use of the right hand. PX 1, pp. 107-110.

Petitioner testified that Respondent did not offer him work within the restrictions imposed by Dr. Baksinski. T. 89. Eventually, after his attorney requested payment (PX 9), Respondent paid him temporary total disability benefits for the period February 13, 2012 through March 12, 2012. T. 89-90.

On February 20, 2012, Petitioner returned to Dr. Wiedrich and reported re-injuring his right wrist while performing taping. Petitioner indicated he had undergone an examination and X-rays following this re-injury.

On examination, Dr. Wiedrich noted diffuse tenderness about the right wrist, slight swelling and no ecchymosis. He reviewed the recent X-rays and interpreted them as showing no arthritis and good overall positioning of the capitate on the radius. He commented that Petitioner "likely had a sudden shift of his capitate on the radius resulting in the stretching or tearing of some scar tissue." He prescribed Naprosyn, released Petitioner to work with no use of the right hand and instructed Petitioner to return in one week. Wiedrich Dep Exh 3, pp. 33-37.

On February 24, 2012, Petitioner's counsel sent a letter via facsimile to Respondent's counsel, requesting that Respondent either provide accommodated duty or bring Petitioner current on benefits. PX 9. Petitioner testified Respondent did not offer him accommodated duty after February 24, 2012. T. 91-92.

Petitioner testified he cancelled an appointment with Dr. Wiedrich on February 27, 2012 so that he could see Dr. Papierski for a re-examination, at Respondent's request. T. 91-92.

When Dr. Papierski re-examined Petitioner on February 27, 2012, he noted that Petitioner had recently resumed working but had experienced a "sudden snap and pain" in his right wrist on his third attempt at a taping procedure.

Dr. Papierski's examination findings were very similar to those documented on December 27, 2011 except that the doctor noted right wrist flexion of 40 degrees, right wrist extension of 45 degrees and 5/5 flexion and extension strength in both wrists.

Dr. Papierski indicated he reviewed a February 13, 2012 accident investigation form along with updated medical records. He described the recent incident as a "temporary sprain or strain of the right wrist, possibly with some scar tissue popping loose, but [with no evidence of] structural damage." He indicated that, while Petitioner might experience swelling and tenderness for a couple of weeks, he would be able to resume his quality assurance duties three to four weeks after the February 13, 2012 temporary aggravation. He indicated Petitioner would likely reach maximum medical improvement from this aggravation within six to eight weeks of February 13, 2012. Papierski Dep Exh 3.

Petitioner next saw Dr. Wiedrich on March 5, 2012. In his note of that date, the doctor indicated that Petitioner again complained of pain over the dorsal and radial aspects of his right wrist. He re-examined Petitioner and obtained right wrist X-rays. He interpreted the films as showing good position of the proximal row carpectomy, no arthritis at the capital radius joint and no fractures or dislocations. He described Petitioner as having "aggravated his wrist on the job." He indicated he wanted to review a job video in order to determine whether Petitioner could perform taping. He instructed Petitioner to return in three to four weeks. He released Petitioner to work with no taping and lifting less than 20 pounds. He sent copies of his note and work restrictions to both Cornicchione and the nurse case manager. Wiedrich Dep Exh 3, p. 43. [The Arbitrator notes that all of Dr. Wiedrich's treatment notes and disability slips are accompanied by letters directed to Cornicchione, with each letter indicating that a carbon copy was being sent to the nurse case manager. Wiedrich Dep Exh 3.]

Petitioner testified that a nurse case manager accompanied him when he visited Dr. Wiedrich. The nurse case manager typically came into the doctor's examining room after the doctor finished his examination but while Petitioner was still present. T. 94.

On March 7, 2012, Petitioner's counsel sent Respondent's counsel a letter via facsimile enclosing Dr. Wiedrich's restrictions and requesting that Respondent either accommodate the restrictions or pay benefits. PX 10. On March 12, 2012, Respondent's counsel sent Petitioner's counsel a letter via facsimile indicating Petitioner was to report to work at 7:00 AM the following day. PX 11.

Petitioner testified he received no temporary total disability benefits after March 7, 2012. T. 97. He reported to work on March 13, 2012, as directed. He was again assigned to quality assurance at an hourly rate of $23.53 and with a guarantee of 42.5 hours per week. T. 98.

Petitioner testified that, on March 13, 2012, he was required to perform heat taping. When he attempted to perform this task, he again felt his wrist pop. He recalled Jared Warrick, a co-worker and a foreman, either Ron Stidman or Ricky (whose last name he could not recall), being present when his wrist popped. T. 98-99. These individuals were present for the express purpose of watching him perform the heat taping. T. 99. After his wrist popped, he experienced swelling and pain. He reported this to the foreman. At the foreman's direction, he then went to the QC office, where he subsequently met with Jared Warrick and Teresa Grilli.

Petitioner testified that Warrick and Grilli did not allow him to go to the company clinic on this occasion. They told him it was a "continuance of an old injury." T. 100-101. Using his own insurance, he went to Alexian Brothers Corporate Health that day. He received a splint and was released to work with no use of the right hand "until cleared by hand specialist." T. 100-101. Petitioner testified that Respondent did not offer him work within these restrictions. T. 101.

Petitioner returned to Dr. Wiedrich on March 19, 2012. T. 101. The doctor's note of that date reflects that Petitioner reported experiencing pain and popping in his right wrist the first day he attempted to resume regular duty. The doctor also noted that Petitioner complained of significant swelling and ecchymosis about the wrist.

On examination, Dr. Wiedrich noted no visible ecchymosis, no crepitation with motion and "no change in the overall swelling of the wrist from prior visits." He indicated that, "with loading and shucking of the wrist," there was "a slight give and pop consistent with [Petitioner's] descriptions of popping." He indicated this was "coming from the area of the radius and capitates due to the congruency of the PRC." He described Petitioner as stable overall. He released Petitioner to work "within the restraints of the FCE." He instructed Petitioner to return to him as needed. Wiedrich Dep Exh 3, pp. 45-46.

Petitioner testified that, on March 19, 2012, he demonstrated the mechanics of heat taping to Dr. Wiedrich at the doctor's request. Petitioner further testified his wrist popped when he simulated this activity. T. 102.

Petitioner testified that Respondent did not offer him work within Dr. Wiedrich's restrictions after March 19, 2012. T. 102.

Petitioner testified that, during this time period, he told Jared Warrick, Teresa Grilli and union representatives he felt he could perform another job at Respondent, namely a janitor position. Respondent did not allow him to perform this position. T. 103.

On May 1, 2012, Dr. Papierski issued an addendum, after reviewing updated records from Dr. Wiedrich along with a Triune job analysis and video dated November 30, 2011. Dr. Papierski noted that the comment section in the job analysis described lifting of no more than 20 pounds but that "the tables themselves actually indicate lifting up to between 26 and 50 pounds occasionally."

Dr. Papierski noted that he had been asked to review this information "with particular attention to the heat taping activity." He indicated there was nothing about Petitioner diagnoses that would preclude him from performing heat taping but conceded Petitioner "may have some symptoms during this kind of activity, as well as other activities utilizing the right hand." Papierski Dep Exh 4.

On May 1, 2012, Edward Rascati, a certified vocational rehabilitation counselor who has operated EJR Consulting, Inc. since 1996 (Rascati Dep Exh 1), prepared a labor market survey at

Cornacchione's request. T. 113. RX 2 at 4-5. Rascati's report reflects he prepared the survey after learning that Petitioner's attorney "would not allow [a] vocational evaluation." Rascati indicated he reviewed records from Drs. Wiedrich and Papierski, along with various job descriptions, Petitioner's job application and work history and the functional capacity evaluation of November 3, 2011. RX 2 at 5-6.

In his report of May 1, 2012, Rascati noted that Petitioner graduated from Steinmetz High School in 1975 and began working for Respondent in May 1978. Rascati indicated that Petitioner held various positions and underwent various types of training while working for Respondent.

Rascati identified fourteen prospective jobs in his report. Six of these jobs appear to be with/through staffing agencies. Most of the hourly salaries (where identified) range from $10 to $16. One machine operator job paid $19 to $22 per hour, "DOE" [depending on experience.] Rascati indicated the average hourly salary was $13.84. RX 2 at 9. Several of the jobs required lifting of 30 to 35 pounds. One job, a meter reader position with Nicor Gas, required "an extreme amount of physical activity," with the applicants needing to be able to walk between 5 and 10 miles per day "while bending, stretching, kneeling and crawling."

Rascati noted that he could not obtain details regarding some of the jobs. In some instances, he relied on the Dictionary of Occupational Titles, which classifies both slitter operator and embosser jobs as "light," meaning that a maximum of 20 pounds is involved.

Rascati also noted there was "some discrepancy" as to Petitioner's lifting requirements, with Dr. Wiedrich referencing the functional capacity evaluation but simultaneously indicating Petitioner was restricted to lifting less than 20 pounds. PX 16. At his deposition, Rascati testified he attempted to use the lifting restrictions recommended by both Dr. Wiedrich [20 pounds] and Dr. Papierski [30 pounds] in identifying prospective jobs for Petitioner. RX 2 at 17-18.

At his deposition, Rascati opined that Petitioner could potentially secure a job earning up to $22 per hour. Rascati further opined that the lowest end of the salary range was $11 per hour. RX 2 at 9-10.

Under cross-examination, Rascati testified that, if he were to consider only unskilled jobs for Petitioner, those jobs would pay between about $8.25 and $11.00 per hour. RX 2 at 11. Rascati testified he was unaware that Respondent had denied Petitioner's request for vocational rehabilitation prior to his involvement. RX 2 at 13. He agrees with the proposition that a physician needs to review the results of a functional capacity evaluation in order to determine a patient's work restrictions. RX 2 at 16. Rascati indicated he was attempting to maximize Petitioner's 20+ years in manufacturing in preparing the labor market survey. RX 2 at 18. He did not discuss Petitioner's restrictions with any of the prospective employers he contacted. He simply inquired as to those employers' needs. RX 2 at 19. He typically "casts a wide net" when looking for prospective employers, especially when he has no opportunity to

perform a vocational evaluation in person. RX 2 at 21. Cornicchione and Respondent's counsel informed him Petitioner had difficulty performing the "heat taping" aspect of the quality assurance job. Dr. Wiedrich restricted Petitioner from performing heat taping. RX 2 at 22-23. If the prospective jobs he identified in his labor market survey required the type of heat taping Petitioner was required to perform for Respondent, those jobs would not be suitable for Petitioner. RX 2 at 23. If Petitioner contacted all of the prospective employers in the survey and received no responses, that would not prompt him to conclude the jobs were unsuitable. He would need more information as to the nature of Petitioner's contact with the employers. RX 2 at 25.

On May 4, 2012, the Arbitrator conducted a pre-trial at the request of both parties. During this pre-trial, counsel for both parties discussed Petitioner's quality assurance job and, specifically, the heat taping aspect of that job, with the Arbitrator. The Arbitrator did not review any job description or video. The Arbitrator recommended that Petitioner try the job again but use his left hand to perform the heat taping.

On May 9, 2012, Respondent's counsel sent Petitioner's counsel a letter directing Petitioner to report to work at 7:00 AM on May 14, 2012. Petitioner testified he did not report to work at that time because he developed a severe case of food poisoning. He called off work for that reason. T. 105. He reported to work on May 16, 2012 and was assigned to quality assurance. He could not recall whether he actually performed any work on that date. T. 105.

On the afternoon of May 17, 2012, Petitioner sought care at the Emergency Room at Northwest Community Hospital. T. 105. Petitioner indicated he had experienced cramping, diarrhea and vomiting since eating at a buffet the previous Saturday. The Emergency Room physician examined Petitioner, noting some epigastric tenderness. He diagnosed gastroenteritis. He instructed Petitioner to stay off work for three days. He indicated Petitioner could resume working on May 20, 2012, assuming he had not experienced a fever for 24 hours. PX 24.

Petitioner testified he saw his family physician, Dr. Small, on May 21, 23, 25 and 30, 2012. Petitioner testified that Dr. Small kept him off work during this period. T. 106.

Petitioner testified he resumed working on May 31, 2012, a Friday, with the understanding that he was going to attempt to use his non-dominant left hand to perform heat taping. Petitioner testified this attempt did not go well. He lacked the necessary strength and coordination and could not apply the tape properly. Petitioner explained that, when heat tape is not put on correctly, it falls off, requiring the worker to "go back and re-do it on the next stitch that they run through the line when they connect two coils together." T. 107. Petitioner testified he resumed using his right hand to perform the heat taping after he was unable to effectively use his left. As soon as he tried using his right hand, the hand became swollen and painful. T. 108.

Petitioner testified he reported to work on Monday, June 3, 2012, and again tried to use his left hand to perform heat taping. He again encountered difficulty and switched to his right hand, at which point his right wrist became painful and swollen. He managed to work only a few hours. He reported his symptoms to his foreman, Ron Stidham, and then sat in the quality control office at Stidham's direction. T. 109. Later the same day, he met with Jared Warrick, Teresa Grilli and Ralph Rosillo. He testified he told these individuals he tried to do heat taping with his left hand but was unsuccessful. He also reported developing symptoms after switching to his right hand. Teresa Grilli reiterated that he was performing a job he had chosen to perform. She also indicated that, if he could not perform this job, he should go home and call his attorney. T. 110. Petitioner testified he asked whether he would be fired if he went home and was told "no." T. 111. Grilli's E-mail of June 4, 2012 confirms Respondent did not fire Petitioner.

On June 6, 2012, Petitioner returned to Alexian Corporate Health and saw Dr. Reese, who imposed work restrictions. T. 111. Records in PX 13 and PX 15 show that Petitioner complained of right arm pain with associated weakness and tingling on June 6, 2012. Dr. Reese prescribed Naproxen and advised Petitioner to see a hand surgeon and use a wrist spica splint he already had. He released Petitioner to restricted duty with the following restrictions to remain in place "until cleared by hand specialist": limited use of the right hand with splint usage, no tight gripping with the right hand and maximum lifting of 5 pounds with the right hand. There is no evidence indicating Petitioner returned to Dr. Wiedrich or any other "hand specialist" after June 6, 2012. Dr. Wiedrich's last note is dated March 19, 2012.

On June 13, 2012, Petitioner's counsel sent Respondent's counsel a letter asking Respondent to provide Petitioner with work within Dr. Reese's restrictions. PX 13. Petitioner testified that, at no point after June 13, 2012 did Respondent accommodate the restrictions or resume paying benefits. T. 112-113. On July 11, 2012, Petitioner's counsel sent Respondent's counsel a letter indicating that Petitioner would begin a self-directed job search if Respondent did not provide accommodated duty by July 20, 2012. PX 14.

Petitioner testified that, as of about July 20, 2012, he began looking for light duty, after preparing a resume with the help of his daughter. He identified PX 17 as the resume. T. 115. [The Arbitrator notes that the second page of the resume reflects Petitioner obtained a high school diploma in 1975.] He kept logs concerning his job contacts. His daughter prepared most of these logs. PX 17.

Petitioner testified that, in the course of his job search, he contacted all but one of the potential employers listed in Ed Rascati's labor market survey. [He explained he did not contact one employer, a gas company, because the job required extensive crawling.] None of the employers he contacted asked to interview him or made him an offer. T. 114-115.

Petitioner testified that, eventually, he found a job with Sunset Pools and Spas. He began working for this company on about May 12, 2013. The job involved driving a truck to various residences and using a "skimmer" to skim leaves off of swimming pools. He earned

$9.00 per hour. His hours varied. During the busy season, he worked 48 hours per week. T. 117. He continued experiencing pain and swelling in his right wrist and thumb but his symptoms were "not as bad." T. 117.

Petitioner testified that Sunset Pools and Spas laid him off on October 17, 2013. He knew the job was coming to an end prior to the layoff. T. 118.

PX 18 consists of a group of Petitioner's weekly paycheck stubs from Sunset Pools and Spas covering the period May 12, 2013 through September 7, 2013.

Petitioner testified he did not receive any benefits from Respondent during the period he worked for Sunset Pools and Spas. After the layoff, he began looking for work again. He had to stop looking for work on about November 25, 2013 because his daughter, who has an addiction problem, had to be hospitalized and he had to assume custody of his grandchildren. His wife could not take care of their grandchildren because she was working. T. 120. Although his daughter got out of the hospital on December 24, 2013, he had to continue caring for his grandchildren after that date because his daughter is taking mandatory classes at the direction of DCFS. Those classes can take place anytime during the day or evening. At such point that his daughter finishes the classes and regains custody of the children, he will resume looking for work.

Petitioner identified PX 18 as a collection of stubs from the paychecks he received from Sunset Pools and Spas. T. 117-118.

Petitioner testified he met with Ed Pagella, a vocational rehabilitation counselor, at his attorney's request. Following the meeting, which took place on October 18, 2013, Pagella made recommendations and devised a vocational plan. T. 118. [In his report of October 24, 2013, Pagella, a certified vocational counselor, indicated he interviewed Petitioner and reviewed a number of documents, including treatment records and Rascati's labor market survey. He agreed, "in part," with Rascati's opinion that Petitioner could earn an average of $13.84 per hour but went on to say that the average fell "more in line with $12.50 per hour." He recommended that Petitioner complete a "career assessment inventory" to determine his vocational interests" and that Petitioner undergo training in job seeking and interviewing techniques. PX 21.]

Petitioner testified he wants Respondent to initiate vocational rehabilitation under Mr. Pagella's direction. T. 122.

Petitioner identified PX 19 as a group of medical bills from Alexian Brothers Corporate Health, Dr. Wiedrich and Alexian Brothers Medical Group. To his knowledge, these bills remain outstanding. If, in fact, some or all of the bills have been paid, he will not claim them. T. 119.

Under cross-examination, Petitioner testified he recalls experiencing popping in his wrist while performing heat taping as a quality assurance operator on May 23, 2011. He had

performed a quality assurance job for Respondent about 25 or 28 years earlier. T. 126. As of May 23, 2011, he was being trained as he worked. Two individuals, Alex Aguirre and a younger man, were training him. T. 127. Petitioner then acknowledged he could not be sure about the date May 23, 2011. Assuming that is the correct date, he could not recall if he finished his shift that day.

Petitioner initially testified it is "possible" the conference call took place on May 23, 2011. A few minutes later, he indicated he received this call in May or June of 2010, after his first surgery. It was his seniority that afforded him the right to choose among 10 or 11 jobs that had become available due to a plant closure. T. 131. It was Bob Grilli who denied his request to have a day or two to think about his choice. He chose the quality assurance job because it was the highest-paying job of the ones he was offered and because he had performed the job in the past. When he performed this job in the past, the job involved heat taping. T. 132.

Petitioner recalled discussing his concerns about heat taping with the individual who performed his November 3, 2011 functional capacity evaluation. That individual noted his concerns. Dr. Wiedrich took this into consideration in setting work restrictions. T. 133.

Petitioner recalled calling off work on Monday, January 16, 2012, the day he was supposed to return to work. He called off work because he had had no sleep and was sick. T. 133. He believes he returned to work the next day and then spent a week watching safety videos, without actually performing any work. T. 134. When he went to work, he produced whatever restrictions Dr. Wiedrich has imposed. He did not produce restrictions dated November 2011. He believes he was offered short-term disability on January 17, 2012. T. 136. He may have watched safety videos on February 7, 2012. The following day, a Wednesday, he called off work because his wrist pain affected his sleep. T. 138. When he called in, he mentioned the lack of sleep but did not mention his wrist. T. 138. On Thursday, February 9, 2012, he underwent safety training. He cannot recall if he was scheduled to work on Friday, February 10, 2012. On Monday, February 13, 2012, he underwent training on the line and, soon thereafter, began developing pain and swelling in his hand. He went off work, sought care and received temporary total disability benefits through March 12, 2012. He believes he attempted to work on March 13, 2012. He would have started work at 7 AM that day. It "could be" that he complained to Jared Warrick of swelling and tingling in his hand at 7:15 AM on March 13, 2012. It is possible he made this complaint before he attempted to perform any work. T. 141. He returned to Dr. Wiedrich after March 13, 2012 and showed the doctor how he positioned his hand while applying heat tape. When he pushed his hand back, his wrist popped. He told the doctor: "this is what happens when my hand is forced back or my wrist is forced back in the opposite direction." T. 143. After the pre-trial, Respondent arranged for him to return to work to see if he could use his left hand to perform heat taping. T. 144. He called in sick on May 14, 2012. He could not recall whether he also called in sick on May 15, 2012. It is possible he presented to work on May 16, 2012 but left because he was feeling sick. T. 145-146. He lost two weeks of work due to food poisoning but cannot recall the exact dates he was off. He applied for, and received, short-term disability for this period. T. 146-147. He returned to work after this period. He last worked for Respondent on June 4, 2012. That day, he

informed his supervisor he was unable to perform the work. He attended a meeting later that day at which he was told he had to perform the job because he had chosen it. At this meeting, Teresa Grilli ultimately told him to go home and call his attorney. T. 148. He started looking for work at some point thereafter. He cannot recall the date he started his job search. Only the tenth page of his job search records is dated. His daughter's handwriting appears on the first nine pages. His handwriting appears on page ten. That page is dated May 3, 2013. That page shows he contacted Crown Services about a picker/packer job. He cannot recall whether he contacted this business via telephone or the Internet. He could not perform the job because of the weight limit. He learned of the job at Sunset Pools and Spas because a former friend, Scott Bianchi, worked there and told him the job fell within his restrictions. T. 152. When he worked at Sunset Pools and Spas, he drove an automatic van to various sites and used two different poles to skim leaves off pools. The poles were retractable. They extended from 8 to 16 feet. One was made of aluminum and the other was made of fiberglass. He used both hands to extend the pole and skim leaves. He used his thumbs to grasp the pole. He hardly had to move his wrists. He usually moved the pole forward and straight back but sometimes moved it side to side. The poles weighed no more than five pounds. He also had to attach a vacuum to the end of the pole and push it into the water. The vacuum weighed 10 to 15 pounds. The vacuum was used to clean the bottom of the pools. The pools were of varying depths. He had to push against the resistance of the water. T. 157. He probably cleaned about 8 to 10 pools per day. He worked five or six days a week. T. 158.

On redirect, Petitioner testified he physically demonstrated the heat tape activity to Dr. Wiedrich. When he did this, his wrist popped. He did not just verbally describe the job to the doctor. T. 159-160. He injured his wrist performing heat taping on March 13, 2012. T. 160. He did not like the idea of attempting the heat tape application with his left hand but he figured he would give it a try. He "did [his] best." T. 161. He attempted to perform the heat taping several times, per Dr. Papierski, even though he was violating Dr. Wiedrich's restrictions. He made these attempts because he wanted to work. T. 161. Dr. Atluri referred him to Dr. Wiedrich. At no point did he go to a doctor he had chosen completely on his own. T. 162. No one associated with Respondent ever told him why Respondent would not accommodate Dr. Wiedrich's restriction. T. 162. He "probably" started looking for work after July 20, 2012 but he "gets [his] dates mixed up." T. 163-164.

Jared Warrick testified on behalf of Respondent. Warrick testified he is currently the director of quality at Respondent's Elk Grove Village facility. In 2012, he was Respondent's plant manager. It was in May or June of 2010 that Petitioner selected a quality assurance position pursuant to the "effects bargaining agreement." This agreement evolved because one of Respondent's plants was closing. The agreement allowed "senior workers," such as Petitioner, to select available jobs so as to retain their seniority. T. 168. Warrick testified he did not become the plant manager until November 2010 and thus was not involved in the discussion that led to Petitioner choosing the quality assurance job. T. 169.

Warrick testified that Petitioner asked to speak with a manager upon arriving at work on January 17, 2012, following his third surgery. T. 174. Petitioner produced a doctor's note

indicating he could not perform heat taping and had a lifting restriction. The note was "old." Warrick discussed this with Teresa Grilli, Respondent's personnel manager. They decided to allow Petitioner to undergo video safety training so as to afford him time to produce more current documentation. Petitioner was able to provide this documentation. T. 175.

Warrick testified that, on March 13, 2012, he talked with Petitioner at 7:15 AM, before Petitioner had performed any work. He asked Petitioner how he was doing. Petitioner told him he had pain in his hand and did not know why he had been directed to return to work. Petitioner began working. The supervisor on duty watched him work, having been instructed to "make sure that all return to work are watched closely." Warrick also observed Petitioner working with Alex Aguirre. T. 172. Warrick observed Petitioner performing "T bends" and taking measurements. Petitioner did not voice any complaints while Warrick was observing him. T. 173. Later that morning, Petitioner "complained of pain again." Neither Warrick nor any supervisor was able to verify that Petitioner sustained a work injury that day. After Petitioner made the complaint, Warrick met with him and a union representative. Petitioner told them he was unable to perform the job.

Warrick, along with the Arbitrator, counsel and Petitioner, then viewed RX 5, a job video taken by Ruben Luna of Triune on or about November 30, 2011. T. 192. Warrick testified he was present when the video was taken. The video accurately depicts the duties involved in the quality assurance job. Warrick testified that the strips used during heat taping are "very tacky" and can be applied using only mild to light finger pressure. T. 177-178, 184. The tape does not have to line up exactly with the metal strip. Even if it is "slightly skewed," it will give an accurate temperature reading. T. 177-178, 190. Warrick testified he has applied heat tape on many occasions. He has filled in for an absent quality assurance operator on occasion. T. 179. The strips of tape are pre-cut into 2- to 3-inch lengths. The worker has to peel each strip off of a backing. He then places the tape on his radio, watch or gear so as to be ready to apply the tape to the metal strip when it arrives. T. 189. Warrick testified he completely disagrees with Petitioner's testimony that he had to use all of his available force to apply the tape. T. 185. Warrick testified he is right-handed. He has never attempted to use his left hand to apply the tape but he "absolutely" believes a worker could do this. T. 189-190.

Warrick testified that, 44 seconds into the video, Alex Aguirre can be seen opening packages of heat tape. T. 194. About 2 minutes and 27 seconds into the tape, Aguirre can be seen applying the heat tape. About 4 minutes and 23 seconds into the tape, Aguirre can be seen recording measurements. T. 196.

Warrick testified that a quality assurance operator can apply heat tape as little as once and as much as eight times during a single shift. The average is 4 to 5 applications per shift. T. 196-197. Each application involves the placement of two pieces of tape. T. 197. The video shows only one heat tape application. T. 198.

Warrick testified that the quality assurance job does not require any lifting over 20 pounds. Workers performing the job have to handle panels that weigh more than 20 pounds

but they "have a cart that they can use." T. 199. The actual lifting requirement is 25 pounds but Respondent considers that "with a single hand." T. 199.

Warrick testified he appears on the tape at the 10 minute, 45 second point. About four minutes later, Aguirre is again seen on the tape, performing a "T-bend." Warrick testified that a "T-bend" involves folding a coated metal strip over on itself and then taping it in order to check the adhesion of the coating to the strip. T. 201.

Under cross-examination, Warrick testified he began working for Respondent in April 2006, at which point Petitioner was working on the slitter. He cannot say whether Petitioner was a good worker because Petitioner did not report to him. T. 202. He did not review Petitioner's personnel file before taking the stand. T. 203. He became the plant manager in 2010. In preparation for the hearing, he reviewed E-mails involving Petitioner that were sent or received after he became the plant manager. One of Respondent's exhibits contains a timeline of events along with E-mails that substantiate this timeline. T. 208.

Warrick acknowledged that the video does not show all aspects of the quality assurance job. A quality assurance worker has to apply heat tape to two types of coaters: finish and prime. The video shows only a finish coater. The two coaters run at the same speed but there is more space on the finish coater on which to affix the heat tape. The video shows a finish coater operating at an "average" speed. T. 210-211. It also shows the standard type of heat tape. T. 212. It is probably easier to apply the non-standard type, i.e., the high temperature tape, because it is wider and affords "more of a grab." T. 213. The video, which is about 14 minutes long, shows only one heat tape application. The application takes place about 1 minute, 42 seconds into the video. Aguirre performs the application, with the whole process taking just a couple of seconds. T. 213. Aguirre's right hand can be seen traveling backward in a rapid motion as he applies the tape "because he was keeping tempo with the strip" as the strip moved overhead. T. 214. Petitioner would have had to perform the application the same way. Warrick testified he cannot say whether or not Petitioner's wrist popped when he tried to perform the application because he was not present to witness the event. T. 215-216. Warrick testified he could not recall exactly how many times Petitioner tried to perform the quality assurance job. On February 13, 2012, Petitioner made an attempt and reported that his wrist popped. An accident report was completed and Petitioner was sent to the clinic. T. 217. Warrick reviewed RX 14 and testified that this exhibit does not contain any doctor's note releasing Petitioner to heat taping. T. 219. Warrick testified he relies on Respondent's human resources department to review doctors' notes and provide return-to-work dates and restrictions. T. 220. On those occasions when Petitioner attempted to perform the quality assurance job, it was Teresa Grilli who provided the restrictions. Warrick testified he was not made aware that Dr. Wiedrich restricted Petitioner from performing heat taping. T. 222. If he had been aware of this restriction, he would not have put Petitioner back to work in quality assurance. The quality assurance job includes heat taping per the current job description but "there are things that can be done to evaluate." Petitioner was asked to attempt heat taping using his left hand. Petitioner made the attempt but reported this did not work well for him. Warrick testified he (himself) never had to use his non-dominant hand to perform heat taping

because he has no problems with his dominant hand. It would take "a little more time" for him to use his non-dominant hand because he would have to go around the coater. T. 225. On the video, Aguirre can be seen "shuffling" along in order to get to the point where the heat tape comes through. T. 225. The following exchange then occurred:

> "Q. Now, if the metal is running at faster speed, though, he probably would have to hurry down there in order to get there on time, correct?
>
> A: Or he could ask somebody else down there to read the heat tape.
>
> Q: Well, as long as there is somebody else down there to read the heat tape, couldn't that somebody else also be there helping Mr. Mays, helping put the heat tape on for him so he can do the other aspects of his job?
>
> A: That's a possibility, but you need to be able to perform all parts of the function yourself in case nobody else is available.
>
> Q: So if Mr. Mays cannot do the heat taping, then he cannot do that QA job, right?
>
> A: He is not fully qualified, no."

T. 226. Because Petitioner was undergoing "buddy training" when he returned to work in February, March and June 2012, he was being observed by Ron Stidham, the line supervisor, per Respondent protocol. T. 226-227. Stidham was involved in the meetings that were held in connection with Petitioner's attempts to return to work. T. 228. The E-mails in RX 16 would contain any statements Stidham made. T. 228.

Warrick testified that, at 7:15 AM on March 13, 2012, Petitioner told him he did not understand why he was at work that day. Petitioner also said, "look, I'm swollen," gesturing to his hand and wrist. T. 229. Petitioner did not mention Dr. Wiedrich's restriction at that time. T. 229.

Warrick testified that, in January 2012, he asked human resources to provide a more updated work release. It was at this point that Respondent had Petitioner undergo safety training, so as to allow Petitioner to obtain an updated release, which he did. T. 231. Petitioner did not perform any work on January 17, 2012. T. 235.

Warrick testified that, on the video, Aguirre can be seen folding metal over itself once. On some occasions, it is necessary to fold the metal over several times. More force has to be applied when folding the metal four or five times. T. 237. The video does not show Aguirre doing this type of folding. T. 237. Warrick testified that Petitioner told him he was having

difficulty doing "T bends." It would not be typical for a quality assurance operator to have someone else perform "T bending" because this is an integral task of the job. T. 238.

On redirect, Warrick testified he did not review records from Dr. Wiedrich or Dr. Papierski. Due to privacy laws, he does not review a worker's medical records in his capacity as plant manager. T. 239. Petitioner was not terminated on the last day he worked. T. 240.

Petitioner was recalled to the stand. Petitioner testified that some of the heat tapes used in quality assurance are lightweight, tacky and easy to apply. Those are the tapes that are shown on the video. They are white in color. Other tapes, which are orange and high temperature, are two to three times thicker and much more difficult to apply. These orange tapes were used "all the time." Sometimes there is water on the metal strip. This makes it "impossible" to get the heat tape to adhere. Sometimes there is light powder on the metal strip and you have to "really push" to get the heat tape to stick. T. 246. The prime coater, which is not shown on the video, affords only a couple of feet of room within which to position yourself while trying to apply the heat tape. T. 247. The video shows Aguirre's arm getting "jerked" backward as he applied the heat tape. T. 249. The goal is to get the heat tape positioned in the center of the coil. Some jobs require application of two to three pieces of heat tape at a time. It is "basically impossible" to do this without using both hands. On the occasion when he made an attempt to perform heat taping using his left hand, his body was further under the strip, which made it more difficult for him to extricate himself so he could move to the next position. T. 251. When the metal strip is running 100 feet a minute, it is somewhat easier to apply the heat tape. When the strip is moving at a faster pace, such as 200 feet a minute, it is more difficult. The speed of the strip on the video is not designated. T. 252. The video showed Aguirre performing a "cero T" bend. This is equivalent to folding a piece of paper. Most of the jobs do not call for "cero T" bends. They require folding of thicker pieces of metal. A "4T" bend involves folding a ¼-inch piece of metal, which is difficult to do. You have to stand up, grab the strip and push it down, using your weight. T. 253.

Petitioner testified the video does not accurately depict heat taping or T bends. T. 254.

Under cross-examination, Petitioner acknowledged that the type of heat tape application shown on the video does take place at Respondent's facility but it is not the only type. The strip shown in the video does not look like it is moving very fast. T. 255. On the day he attempted to use his left hand to perform heat taping, he worked for only an hour or two. He is basing his testimony on this attempt. With the prime coater, the strip moves at a height that is a little less than 5 feet. With the finish coater, the height is a little over 5 feet. Regardless of which coater was involved, he had to stoop while performing heat taping. T. 257.

Warrick testified he is aware Petitioner underwent a functional capacity evaluation but he does not recall when the evaluation was performed. T. 233.

As indicated above, Respondent offered into evidence Dr. Papierski's deposition of April 12, 2013. Dr. Papierski acknowledged that Petitioner never described heat taping to him in any

detail. RX 3 at 14. He viewed a video of the quality assurance operator job. RX 3 at 15-16. Based on the video, he saw no need to restrict Petitioner from performing heat taping with his right hand. He did not believe that Petitioner would be inhibited from using his non-dominant left hand to perform heat taping. RX 3 at 18.

Under cross-examination, Dr. Papierski testified a worker may be able to continue a particular work activity despite experiencing symptoms from that activity, so long as the activity does not further damage or aggravate the underlying condition. RX 3 at 22. He conceded that Petitioner might become symptomatic while performing the quality assurance operator job. RX 3 at 23. Based on the measurements he took, Petitioner's right wrist flexion is "about 50 percent of what would be considered normal." RX 3 at 25. In February 2012, he noted tenderness with attempted Finkelstein's maneuvering along with a 5 millimeter gap in "pulp to palm" testing. He had not noted these findings when he examined Petitioner in December 2011. RX 3 at 26-28. These findings were indicative of a decrease in flexibility and range of motion of Petitioner's right thumb. RX 3 at 29. The job description he reviewed did not describe the type of tape Petitioner applied. Nor did it describe the force required to apply the tape. He did not receive any samples of the heat tape. RX 3 at 31-32. He cannot recall what type of motion was needed in order to remove the tape from the dispenser. RX 3 at 37. Heat taping could cause Petitioner to become symptomatic. RX 3 at 38. The person who performed the November 2011 functional capacity evaluation noted that Petitioner grimaced when performing a heat tape simulation. RX 3 at 36-37.

Dr. Papierski testified he did not have enough information to determine the underlying cause of the "popping pain" Petitioner complained of when doing heat taping. RX 3 at 39-40. If a patient of his experienced pain with a particular activity, he might or might not restrict the person from performing that activity. Before imposing a restriction, he would want to know what was going on from an anatomical perspective that was causing a sensation of popping and/or pain. RX 3 at 42. It would be reasonable to restrict a patient from performing that activity while investigating that underlying cause. RX 3 at 42. When he examined Petitioner, there was no indication that Petitioner was feigning or exaggerating his symptoms. RX 3 at 43. It was "potentially" reasonable for Dr. Wiedrich to restrict Petitioner from heat taping. RX 3 at 43.

Dr. Papierski testified that the initial work accident was a competent cause of the right wrist injury Petitioner sustained. The treat Petitioner received was reasonable. Petitioner's injury resulted in some degree of permanent impairment. It was appropriate to restrict Petitioner from full activity. RX 3 at 44.

Dr. Papierski testified that, on average, he devotes about 10 to 15 percent of his time to conducting independent medical examinations. RX 3 at 45, 51. About 90 percent of the examinations he performs are requested by employers or insurance carriers. RX 3 at 51. He and Dr. Atluri worked at the same hand surgery practice but not concurrently. RX 3 at 52. He left that practice because he was in the Air Force reserve and got called to active duty. RX 3 at 53. When scar tissue tears loose, following a surgery such as a de Quervain's release,

symptoms such as bleeding, swelling and pain can occur. These symptoms typically improve over time. RX 3 at 54. It is not typical for additional scar tissue to form during this improvement period. RX 3 at 55. If scar tissue tears loose, it can potentially re-adhere and later pop loose again. RX 3 at 56. This would be rare but not unheard of. RX 3 at 56.

[CONT'D]

Arbitrator's Credibility Assessment

The Arbitrator finds credible Petitioner's testimony that he experienced painful popping in his right wrist when he attempted, on several occasions, to perform "heat taping" while being trained to perform a quality assurance operator job. Petitioner's credibility on this point is enhanced by the deposition testimony of Respondent's examiner, Dr. Papierski. Dr. Papierski explained that Petitioner's right wrist does not flex in a normal manner because of the partial fusion that was part of the carpectomy procedure. Dr. Papierski readily acknowledged that heat taping would cause Petitioner's wrist symptoms to flare. Dr. Papierski asserted that the flare of symptoms should not prevent Petitioner from being able to perform the task, since it would not be accompanied by structural changes inside the wrist, but also conceded that the February 13, 2012 accident, which occurred when Petitioner attempted to perform heat taping, did result in a structural change, in that the effort associated with the task likely caused scar tissue inside the wrist to break away.

The Arbitrator views Petitioner's multiple attempts to perform the quality assurance operator job as made in good faith. Petitioner made the attempts even though his surgeon, Dr. Wiedrich, had restricted him from heat taping. Heat taping is a small but integral part of the quality assurance operator job. Respondent's witness, Jared Warrick, conceded that a person is not qualified to perform the job if he cannot perform heat taping.

Respondent tried to portray Petitioner as a defeatist or shirker, citing, in part, Warrick's testimony that, on March 13, 2012, Petitioner stated he was unable to perform the job before he even punched in. T. 170-171. Warrick did testify to this but went on to say that Petitioner did, in fact, make an attempt to perform the job that day. It was the complaint that Petitioner made later that day, after trying to perform the job, that prompted Warrick to complete a report, although Warrick asserted he could not verify that an actual injury occurred. T. 173.

Based on a pre-trial held on May 4, 2012, the Arbitrator was under the impression that it was solely the heat taping aspect of the job that was problematic for Petitioner. At the hearing, Arbitrator watched a job video (RX 5) and heard about other tasks, primarily "T bends," that were also problematic. Petitioner credibly testified on rebuttal that T bending could involve folding a ¼-inch strip of metal several times over. Warrick also conceded that the job sometimes required lifting of panels that weighed over 20 pounds, although he said a cart was available to the workers. The implication is that the worker would have to lift the panel into the cart in order to utilize the cart. Petitioner was restricted to lifting 20 pounds per Dr. Wiedrich.

Arbitrator's Conclusions of Law Relative to 12 WC 17346

Did Petitioner sustain an accident arising out of and in the course of his employment on March 13, 2012?

The Arbitrator finds that Petitioner sustained a compensable work accident on March 13, 2012. Petitioner testified he reported to work that day pursuant to a directive from Respondent. T. 97-98. He further testified he attempted to perform heat taping that day but again experienced popping in his right wrist. T. 97-98. He indicated several individuals, including his foreman and Jared Warrick, observed him as he made this attempt. T. 98-99. He reported the wrist popping to his foreman and subsequently met with Warrick and other individuals. T. 99-100.

Under cross-examination, Petitioner acknowledged he might have complained to Warrick of right wrist pain shortly after arriving at work on March 13, 2012, before performing any actual duties. Warrick also testified to this. Warrick confirmed, however, that, despite these complaints, Petitioner began working, while being closely observed by his supervisor (who did not testify), and "again complained of pain" later that morning. T. 169-172.

The word "accident," as used in the Act, is not a technical legal term. Rather, it is a "comprehensive term almost without boundaries." Ervin v. Industrial Commission, 364 Ill. 56, 60 (1936). An "accident" does not have to consist of a fall or other dramatic event. It can consist of the onset of pain and/or bodily collapse while performing work duties. As such, Petitioner established an accident of March 13, 2012.

The Arbitrator also finds there is no logical basis for distinguishing between the events of February 13, 2012, which Respondent treated as an accident, and those of March 13, 2012.

Did Petitioner establish a causal connection between his accident of March 13, 2012 and his current right wrist condition of ill-being?

The Arbitrator finds that Petitioner's current right wrist condition is multi-factorial and that the accident of March 13, 2012 was a cause of that condition.

What are Petitioner's earnings? Is Petitioner entitled to temporary total disability benefits? Is Respondent entitled to credit?

The Arbitrator finds that Petitioner established an average weekly wage of $1,000.03 as of his March 13, 2012 accident. No one refuted Petitioner's testimony as to the hourly wage and weekly schedule (i.e., 42.5 hours per week) associated with the quality assurance operator job he attempted to perform on said date. In fact, Respondent premised much of its defense on Petitioner having "chosen" this job.

In the instant case, Petitioner seeks two intervals of temporary total disability benefits: 1) March 14, 2012 through May 13, 2012; and 2) June 4, 2012 through July 20, 2012. Arb Exh 3.

Respondent asserts a credit for $1,106.70 in benefits it paid to Petitioner. Petitioner acknowledges this payment but asserts the payment represented short-term non-occupational disability, not temporary total disability. Arb Exh 3.

The Arbitrator awards temporary total disability benefits from March 14, 2012 (the day after the March 13, 2012 accident) through March 19, 2012, the day on which Dr. Wiedrich noted no new findings and described Petitioner's right wrist as relatively stable. This is a period of 6/7 weeks. While Petitioner experienced increased right wrist pain on March 12, 2012, Dr. Wiedrich described Petitioner's right wrist as relatively stable as of March 19, 2012. Dr. Wiedrich released Petitioner from care on a "PRN" basis on March 19, 2012. There is no evidence indicating Petitioner returned to Dr. Wiedrich after March 19, 2012. Petitioner did seek care at Alexian Corporate Health on June 6, 2012, a couple of days after he made a final attempt at the quality assurance operator job, with Dr. Reese imposing restrictions pending a hand specialist consultation, but Petitioner did not see Dr. Wiedrich or any other hand specialist thereafter. The Arbitrator views Petitioner's right wrist condition as stabilizing as of March 19, 2012. Interstate Scaffolding v. IWCC, 236 Ill.2d 132 (2010).

The Arbitrator declines to award Respondent credit (either under Section 8(j) or as against the awarded TTD) for the $1,106.70 in benefits it paid to Petitioner. The evidence shows Respondent made this payment while Petitioner was off work undergoing treatment for a non-work-related gastrointestinal ailment. Petitioner does not claim temporary total disability benefits during this time.

What are Petitioner's earnings? Is Petitioner entitled to temporary partial disability benefits?

Petitioner claims temporary partial disability benefits from May 23, 2013 through October 18, 2013. He testified he worked for Sunset Pools and Spas during this period. Petitioner testified he earned $9.00 per hour at this job and worked varying numbers of hours per week. He introduced his paycheck stubs (PX 18) into evidence but the stubs cover only the period May 12, 2013 through September 7, 2013. Because the Arbitrator views Petitioner as a good candidate for vocational rehabilitation, at least potentially (see further below), she finds it appropriate to award temporary partial disability benefits rather than wage differential benefits during this period.

Section 8(a) of the Act provides that temporary partial disability benefits are awardable when an injured worker is performing light duty on a part- or full-time basis and is earning less than he would be if he were engaged in the full capacity of his regular job. The benefits are to be awarded at a rate equal to 2/3 of the difference between the average amount the worker would be able to earn in the full performance of his duties in the occupation he was engaged in at the time of the accident and the gross amount he is earning in the part- or full-time light duty job.

The Arbitrator elects to award temporary partial disability benefits only during the period supported by the paycheck stubs in evidence, i.e., May 12, 2013 through September 7, 2013:

Pay Period	Weekly Pay (Gross)	$1,000.03 – Gross	x 2/3rds = TPD
5/12/13 – 5/18/13	$633.38	$366.65	$244.43
5/19/13 – 5/25/13	$ 85.50	$914.53	$609.69
5/26/13 – 6/1/13	$ 586.13	$413.90	$275.93
6/2/13 – 6/8/13	$ 454.50	$545.53	$363.69
6/9/13 – 6/15/13	$ 684.00	$316.03	$210.69
6/16/13 – 6/22/13	$ 603.00	$397.03	$264.69
6/23/13 – 6/29/13	$ 576.00	$424.03	$282.69
6/30/13 – 7/6/13	$410.63	$589.40	$392.93
7/7/13 – 7/13/13	$505.13	$494.90	$329.93
7/14/13 – 7/20/13	$478.13	$521.90	$347.93
7/21/13 – 7/27/13	$481.50	$518.53	$345.69
7/28/13 – 8/3/13	$403.88	$596.15	$397.43
8/4/13 – 8/10/13	$407.25	$592.78	$395.19
8/11/13 – 8/17/13	$360.00	$640.03	$426.69
8/18/13 – 8/24/13	$465.75	$534.28	$356.19
8/25/13 – 8/31/13	$229.50	$770.53	$513.69
9/1/13 – 9/7/13	$324.00	$676.03	$450.69

Is Petitioner entitled to maintenance benefits?

Petitioner seeks two intervals of maintenance benefits: July 21, 2012 through May 22, 2013 and October 19, 2013 through January 21, 2014 (the date of hearing). Respondent disputes this claim, arguing that Petitioner abandoned his quality assurance job. Arb Exh 3. Respondent also argues that Petitioner is not entitled to maintenance because he did not place vocational rehabilitation at issue until a scheduled trial date in October 2013.

The Arbitrator does not agree with Respondent's "job abandonment" argument because the Arbitrator does not view the quality assurance job as physically appropriate for Petitioner. The Arbitrator also views Petitioner as placing vocational rehabilitation at issue on July 20, 2012. The Arbitrator further notes that a claimant is not required to formally request vocational rehabilitation. Roper Contracting v. Industrial Commission, 349 Ill.App.3d 500, 505 (5th Dist. 2004).

The Arbitrator awards maintenance from July 21, 2012 (the day after Petitioner's counsel alerted Respondent's counsel that Petitioner would be starting a self-directed job search) through May 11, 2013 (the day before Petitioner began working at Sunset Pools and Spas). Petitioner testified he began looking for work after July 20, 2012. Petitioner also

testified he contacted all but one of the prospective employers identified in Ed Rascati's labor market survey. Petitioner did eventually find a job, which he began performing on May 12, 2013.

The Arbitrator declines to award additional maintenance after September 7, 2013, the last documented date on which Petitioner worked for Sunset Pools and Spas. Petitioner testified he resumed looking for work after being laid off by Sunset Pools and Spas in October 2013 but the Arbitrator questions this testimony. Petitioner acknowledged he completely stopped looking for work on November 25 or 27, 2013, at which point he assumed responsibility for his grandchildren while his daughter underwent treatment for drug addiction. Petitioner indicated his wife was not available to act as a caretaker because she was working. The Arbitrator has nothing but admiration for Petitioner for assuming the care of his grandchildren but cannot understand how this responsibility prevented him from continuing to look for work at night and on the weekend, when his wife was not working. Petitioner also argues he would not have been able to effectively look for work after November 25 or 27, 2013 because he lacked a high school degree and needed his daughter's assistance. Ed Pagella indicated Petitioner attended only two years of high school and lacked a GED but the Arbitrator notes that Petitioner describes himself as having a diploma from Steinmetz High School in his resume. PX 17, p. 2. At no point during his lengthy testimony did Petitioner claim to have stopped attending high school after only two years. Ed Pagella specifically noted that Petitioner reported being able to perform a job search via the Internet. PX 21, p. 3.

In short, the Arbitrator views Petitioner as having removed himself from the labor market.

Is Petitioner entitled to vocational rehabilitation?

In theory, Petitioner is a very good candidate for vocational rehabilitation, given his 31-year tenure at Respondent and the variety of jobs he performed during that period. The two vocational experts who rendered opinions in this case agreed that Petitioner is employable. Petitioner demonstrated his ability to work by securing a seasonal job at Sunset Pools & Spas. After this job ended, however, Petitioner removed himself from the labor market so that he could tend to his grandchildren. At the hearing, Petitioner acknowledged he was still not in a position to look for work. The Arbitrator thus views Petitioner's claim for vocational rehabilitation as premature. The Arbitrator directs Respondent, in consultation with Petitioner and his attorney, and giving consideration to the thorough assessment previously prepared by Ed Pagella (PX 22), to prepare a written vocational assessment, with that assessment to be updated periodically thereafter, in accordance with Section 7110.10 of the Rules Governing Practice Before the Workers' Compensation Commission. As the Appellate Court noted in Ameritech Services, Inc. v. IWWC, 389 Ill.App.3d 191, 207-8 (1st Dist. 2009), Rule 7110.10 requires the preparation of an assessment "even in circumstances where no plan or program of vocational rehabilitation is necessary or appropriate."

Is Petitioner entitled to reasonable and necessary medical expenses?

Having found in Petitioner's favor on the issues of accident and causal connection, the Arbitrator awards Petitioner the $127.00 in expenses associated with his visit to Dr. Wiedrich on March 19, 2012, pursuant to the fee schedule. PX 19.

Is Respondent liable for penalties and fees?

The Arbitrator declines to award penalties and fees on the awarded temporary total disability, temporary partial disability and/or maintenance benefits, as requested by Petitioner. While the Arbitrator has elected to assign greater weight to the opinions of Dr. Wiedrich than to those of Dr. Papierski, the Arbitrator is unable to find that Respondent acted vexatiously and unreasonably in relying on Dr. Papierski's opinions as to Petitioner's work capacity.

STATE OF ILLINOIS)
) SS.
COUNTY OF DU PAGE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Terrence Johnson,

Petitioner,

15IWCC0022

vs.

NO: 02 WC 9171

Elmhurst Public School District #205,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent and Petitioner herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical expenses, credit under §8(j) and permanent partial disability and being advised of the facts and law, reverses the Decision of the Arbitrator on the issue of causal connection as stated below. Finding that Petitioner's condition after March 30, 2004 was no longer related to the July 25, 2000 accident, we award payment of medical bills only through March 30, 2004 and permanent disability benefits under §8(d)(2) to the extent of 10% loss of the person as a whole.

Petitioner, a 35-year-old maintenance worker with a history of chronic headaches, accidentally hit his forehead on the edge of the open door of a backhoe on July 25, 2000. The backhoe was stationary when Petitioner accidentally walked into it. He testified that he immediately dropped to his knee and "saw stars," but did not lose consciousness. He testified that he promptly began to experience right-sided headaches. Petitioner claims that the accident of July 25, 2000 caused him to develop occipital neuralgia – a condition for which he has received extensive medical treatment. Ultimately, permanent electronic stimulators were implanted in his head and chest wall. Petitioner continues to work full duty for Respondent. He testified that his acute pain is managed by activating the implanted nerve stimulator, but that he continues to suffer from multiple disruptive symptoms that reduce his quality of life.

On July 25, 2000, Petitioner was seen at the Elmhurst Memorial Hospital emergency room and reported hitting his head when he walked into a door. He was noted to have a small superficial injury to his upper forehead on the right side, but the injury did not require stitches or

bandages. At hearing, Petitioner agreed that the small scrape healed without leaving any visible scar. Petitioner was subsequently seen in the emergency room at Elmhurst Memorial Hospital on July 31, 2000, August 2, 2000 and August 8, 2000 and Loyola University Hospital on August 7, 2000. During these emergency room visits, Petitioner complained of headaches with blurred vision, dizziness and right eye blinking or twitching. CT scans of Petitioner's head on July 31, 2000 and August 7, 2000 were unremarkable.

Petitioner was seen by Dr. Fuller, a neurologist, on August 12, 2000 on referral from his primary care physician, Dr. Young. Petitioner reported a past medical history of headaches and having had a CT scan for headaches even prior to the July 25, 2000 accident. Petitioner complained of headaches, forgetfulness, eye twitching, neck stiffness and dizziness. He reported that since the accident a friend noticed that Petitioner's eyes were "rolling." Petitioner also claimed to veer off to the right or left side when walking. Dr. Fuller diagnosed a cerebral concussion and prescribed the antidepressant Elavil. She noted that Petitioner's mental status testing was normal. Petitioner returned to Dr. Young on August 30, 2000. Dr. Young noted that Petitioner had "a variety of ominous new symptoms since his visit to Dr. Fuller." He noted Petitioner's preexisting history of headaches with negative objective findings. He observed that Petitioner presented himself as somewhat confused and walked with an unstable gait. Petitioner returned to Dr. Fuller the following day, and Dr. Fuller noted that Petitioner's subjective symptoms were worse but that Petitioner's neurological exam, MR angiogram and EEG were normal. She recommended repeating the MR angiogram with gadolinium to rule out vertebral artery dissection and she continued to prescribe Elavil. At Petitioner's return visit on September 14, 2000, Petitioner reported that his symptoms had resolved and that he had weaned himself off of Elavil. Dr. Fuller noted that a cervical spine MRI, brain MRI and repeated MR angiogram were normal and she released Petitioner from care.

On October 16, 2000 Petitioner returned to Dr. Fuller and reported that his symptoms had returned and were severe. He complained of headaches with pressure and throbbing at the top of his head, lightheadedness, photosensitivity and right eye blinking. Dr. Fuller recommended Petitioner resume taking Elavil. Petitioner testified, and the records of Dr. Young indicate, that while Elavil improved Petitioner's headaches, he believed he could not take it while concurrently undergoing fertility therapy with his wife. Petitioner claimed that he no longer had his "usual" headaches, and that his "new" headaches were related to the accident and becoming worse.

Petitioner began seeing a second neurologist, Dr. Fischer at Loyola University, on February 5, 2001. Dr. Fischer believed that Petitioner's history and symptoms indicated posttraumatic headaches with a migrainous component; he prescribed the antidepressant Nortriptyline and the migraine medication Imitrex. Petitioner returned to Dr. Fisher on March 13, 2001 and reported that his headaches decreased with medication but he complained that his memory was worsening. Dr. Fischer recommended neuropsychological testing.

Dr. Schenker examined Petitioner at the request of Respondent on March 28, 2001. Dr. Schenker was a neurologist at Rush University. Petitioner explained that he walked into the door of a piece of machinery on July 25, 2000, striking the top of his head on the right side. Petitioner reported "seeing stars" and having an immediate headache. Petitioner also reported that a friend noted that Petitioner spoke incoherently and walked into things within a few days of the accident. Dr. Schenker noted that Petitioner had been examined by neurologists and had negative objective findings. Petitioner reported that he was taking the antidepressant Nortriptyline for pain. Due to nausea, Petitioner reported that he chose to take the medication every other day. Petitioner also

claimed that his memory was declining. Dr. Schenker did not believe that Petitioner's minor blow to the head explained the myriad symptoms from severe headaches to memory loss and twitching of the eye. Dr. Schenker noted Petitioner's preexisting history of headaches and potentially contributory conditions of hypertension and obesity. On a "mini mental status test" Petitioner's results were normal; he was alert and oriented, he followed commands well and made no aphasic errors or involuntary movements. Dr. Schenker noted that Petitioner shook his head in a "bizarre" manner while flexing and extending his neck. Dr. Schenker opined that there was no causal relationship between Petitioner's current symptoms and the accident of July 25, 2000. Dr. Schenker opined that no further treatment was necessary but that Petitioner should take his medication as prescribed by Dr. Fischer.

Petitioner returned to Dr. Young on April 25, 2001. Dr. Young noted that Dr. Fischer could not find "anything" and that Petitioner now had three normal neurological examinations and was no longer covered by workers' compensation insurance. Petitioner reported that his headaches were slightly improved by Nortriptyline but he again complained of worsening memory problems and right eye twitching. Dr. Young referred Petitioner for pain management treatment.

At the University of Chicago Pain Clinic, Petitioner came under the care of Dr. Dhesi and Dr. Muslim. Dr. Dhesi diagnosed idiopathic headaches with a possible neuropathic component. Between May 18, 2001 and November 2, 2002 Petitioner underwent a series of three right-sided occipital nerve blocks and a median nerve block at C2-3. Dr. Muslim performed a radiofrequency ablation procedure on the right occipital nerve on July 29, 2003.

On March 30, 2004, Petitioner was seen at the University of Chicago Pain Clinic and reported that he had recently been involved in a motor vehicle accident. He complained that his pain returned at a level of 7/10 after a period of complete relief from the radiofrequency ablation procedure. Petitioner received a right occipital Lidocaine injection and was issued prescriptions for Vioxx and Ultram. Petitioner testified that prior March 30, 2004, he had not had any treatment since July of 2003 and during that time he was free of headaches.

To address Petitioner's recurrent symptoms, Petitioner underwent trigger point injections, Botox injections, and a second radiofrequency ablation. Despite treatment, Petitioner reported that his symptoms were not improving. In October of 2004 Petitioner began seeing an orthopedic doctor for cervical complaints of pain and stiffness. Dr. Koutsky at Elmhurst Orthopedics interpreted a cervical MRI study as unremarkable other than loss of cervical lordosis. Petitioner was thereafter involved in two minor motor vehicle accidents occurring in November of 2004 and January of 2005. Petitioner was able to drive away from both accidents and did not seek medical attention. Petitioner submitted the crash reports into evidence at hearing. On February 10, 2005, he underwent surgery with Dr. Muslim at the University of Chicago Hospital for attachment of a temporary occipital nerve stimulator. The temporary device was replaced on May 17, 2005. Petitioner again underwent trial implantations of nerve stimulators in his head and chest in February and May of 2005.

On June 15, 2005, Petitioner was examined by Dr. Curry in the Department of Neurosurgery at the University of Chicago. Dr. Curry recommended a permanent occipital nerve stimulator and the procedure was performed on July 8, 2005. On July 21, 2005, Petitioner reported no headaches. On August 11, 2005, Dr. Curry found that Petitioner was doing well and he released Petitioner from active care and allowed Petitioner to return to full duty work.

Petitioner was once again examined by Dr. Schenker at the request of Respondent on December 16, 2005. Dr. Schenker reviewed Petitioner's updated medical records. Petitioner explained that he had been in two traffic accidents, one that wrecked his vehicle. However, he did not feel that he had been injured in either accident and he did not go to the hospital. Petitioner presented with some pain and irritation at the incision sites at his chest and occipital region; his physical exam was otherwise normal. Dr. Schenker opined that Petitioner's subjective complaints were not supported by objective evidence. He did not believe that Petitioner suffered from occipital neuralgia, myofascial pain syndrome, cervical facet joint disease or any neurological impairment. Dr. Schenker opined that the treatment at the University of Chicago Pain Clinic and Elmhurst Orthopedics was not related to the work accident, that Petitioner could work without restrictions and did not sustain any permanent disability as a result of the soft tissue injury to the forehead sustained on July 25, 2000.

Petitioner subsequently began to complain of pain and discomfort in the area of the stimulator during the winter of 2005. Dr. Curry concluded that a malfunction was causing Petitioner to experience shocks or "zaps," and he replaced the stimulator on March 26, 2006.

Dr. Schenker performed a record review at the request of Respondent on November 29, 2006 after reviewing further records; he did not change any of his opinions. He believed that Dr. Curry did not obtain a detailed accident or medical history from Petitioner. He believed that Dr. Curry discounted Petitioner's history of preexisting headaches and the motor vehicle accidents that occurred subsequent to the July 25, 2000 work-related accident. On July 21, 2009, Dr. Schenker testified that Dr. Curry's causal opinion was not reliable; because headaches are inherently subjective, Dr. Schenker explained that a consistent and reliable history is extremely important. Dr. Schenker also noted that Dr. Curry only treats end-stage patients and does not follow patients while they are still undergoing conservative treatment. This is a characterization that Dr. Curry also applied to himself during his deposition testimony.

Petitioner continued to complain of localized pain and discomfort in the area of the generator despite the replacement. He reported additional problems to Dr. Muslim in the fall of 2007. He now complained of soreness and irritation at the area of the generator, but no headaches. Petitioner continued to take pain medication, muscle relaxers and sleep medication, but complained that his pain at the area of the stimulator was becoming sharper. Petitioner was started on Oxycontin and Topamax and injections and nerve blocks were administered in August and October of 2008 and March and May of 2009.

Dr. Curry testified via deposition on April 22, 2009, after not having seen Petitioner for several years. Dr. Curry now works in Texas as a pediatric neurosurgeon. Dr. Curry testified that by the time he saw Petitioner, conservative treatment had been exhausted and he understood that he was seeing Petitioner specifically for surgical options for occipital neuralgia. Dr. Curry testified that occipital neuralgia is sharp pain that is usually intermittent and which follows the distribution of the occipital nerve. He testified that he relied on Petitioner's history for his opinion that the accident is causally related to Petitioner's occipital neuralgia. He believed that it was possible to develop occipital neuralgia related to blunt trauma to the front of the head, even though the occipital nerve originates at the back of the head. He agreed that whiplash-type injuries can also be causally related to occipital neuralgia. He recalled that there was some mention of motor vehicle accidents in Petitioner's history, but he did not recall any dates or descriptions of the occurrences. Dr. Curry also testified that occipital neuralgia can be related to

multiple physical factors from certain headwear to traumatic injury and that it can also be idiopathic. He testified that negative CT scans and MRI scans are not uncommon in patients with occipital neuralgia. Dr. Curry testified that one-sided headaches are the primary complaint of a typical patient. He did not believe that symptoms of photosensitivity, eye-twitching, lightheadedness or disequilibrium were reliable indicators of occipital neuralgia. Dr. Curry believed that Petitioner had been successfully treated by the permanent stimulator and for that reason he released Petitioner to return to full duty work. He testified that the stimulator suppresses symptoms but it does not cure occipital neuralgia.

Petitioner was seen on an emergency basis on October 16, 2009. A trial for a percutaneous lead placement was done on November 6, 2009, and Petitioner subsequently reported a 50% improvement in pain. An occipital dorsal column stimulator trial lead was placed on July 2, 2010. Petitioner continued to be treated with oral medications and intravenous infusions of opiates for pain control. On January 23, 2012, an exchange of IPG for occipital nerve stimulator and insertion of a new electrode into the right pectoralis region was performed. On April 18, 2012, Petitioner reported a 50% improvement of his pain to Dr. Muslim. He continued to take oral painkillers. The last report from Dr. Muslim is dated December 21, 2012. Petitioner reported that the new lead placement gave him effective pain relief but he did not like to use it for long periods of time because it caused chest wall irritation.

The accident itself was not disputed, but Respondent denied Petitioner's worker's compensation claim based on a lack of causal connection between Petitioner's occipital neuralgia and the July 25, 2000 accident. Respondent relied on the opinion of its expert, Dr. Schenker, that there was no objective evidence of neurological impairment and that Petitioner's "minor" head injury is not causally related to Petitioner's need for invasive treatment in the form of implanted stimulators. The Arbitrator found the opinion of Petitioner's treating physician, Dr. Curry, to be more persuasive. The Arbitrator awarded 25% loss of the person as a whole under §8(d)(2) and reasonable and necessary medical expenses with credit to respondent of $173,203.87 pursuant to §8(j). After examining the entire record, we reverse the Arbitrator's decision on the issue of causal connection. We conclude that the Arbitrator's finding of causal connection between the Petitioner's current condition of ill-being and the work injury of July 25, 2000 is not supported by the evidence. We find that the Arbitrator and Dr. Curry overestimated the severity of the injury to Petitioner's forehead in a manner inconsistent with the medical records. Further, evidence shows a bizarre and inconsistent progression of symptoms despite the failure of multiple neurologists to identify any reasonable neurological explanation causally connected to the minor head injury. Furthermore, we find it highly relevant that Petitioner had a personal and family history of chronic idiopathic headaches and we are not persuaded by Petitioner's claim that his "regular" headaches resolved and that instead all of his complaints were related to the July 25, 2000 accident and not his pre-existing condition nor the three subsequent motor vehicle accidents he sustained. The totality of the medical records show an escalation of invasive procedures after March 30, 2004 when Petitioner reported to Dr. Muslim that he had recently been involved in a motor vehicle accident and that his pain had returned.

We conclude that causal connection was severed as a result of the motor vehicle accident of March 2004. There can be no doubt that the motor vehicle accident that occurred in March of 2004 altered the course of Petitioner's treatment. Petitioner obtained permanent relief from headaches as a result of the radiofrequency ablation procedure administered by Dr. Muslim on July 29, 2003. He had no further treatment until March 30, 2004, at which time he reported a significantly increased level of pain. Therefore, we award payment of medical bills to

March 30, 2004 and find permanent disability under §8(d)(2) to the extent of 10% loss of the person as a whole with respect to the accidental injury sustained on July 25, 2000.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $483.32 per week for a period of 50 weeks, as provided in §8(d)(2) of the Act, for the reason that the injuries sustained caused the 10% loss of the person as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the reasonable and necessary medical expenses related to the July 25, 2000 accident under §8(a) of the Act but only through March 30, 2004.

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: JAN 1 2 2015
RWW/plv
o-11/12/14
46

Ruth W. White

Charles J. DeVriendt

Daniel R. Donohoo

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Ramon Rodriguez,
Petitioner,

vs.

15IWCC0023
NO: 13 WC 11119

Aramark,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 8, 2014 is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $27,200.00. 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: JAN 12 2015
KWL/vf
O-1/6/15
14

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

15IWCC0023

RODRIGUEZ, RAMON
Employee/Petitioner

Case# **13WC011119**

ARAMARK
Employer/Respondent

On 4/8/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% 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:

2675 COVEN LAW GROUP
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CHICAGO, IL 60601

1739 STONE & JOHNSON CHTD
PATRICK DUFFY ESQ
111 W WASHINGTON ST SUITE 1800
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

15IWCC0023

Ramon Rodriguez
Employee/Petitioner

v.

Aramark
Employer/Respondent

Case # **13** WC **11119**

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 **Lynette Thompson-Smith**, Arbitrator of the Commission, in the city of **Chicago**, on **February 21, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

15IWCC0023

FINDINGS

On **February 26, 2013**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$88,658.44**; the average weekly wage was **$1,704.97**.

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

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

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

Respondent shall be given a credit of **$11,691.26** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$11,691.26**.

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $1,136.64/week for 10 2/7 weeks, commencing April 15, 2013 through June 25, 2013, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner PPD benefits of $712.55/week for 43 weeks, because the injuries sustained caused a 20% loss of use of the right leg, as provided in Section 8(e)(12) of the Act.

Respondent shall be given a credit of $11,691.26 for temporary total disability paid to Petitioner.

Respondent shall be given a credit of $3,509.71 for temporary partial disability paid to Petitioner.

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

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

Statement of Facts

The disputed issues in this matter are: 1) causal connection; 2) temporary total disability; and 3) the nature and extent of Petitioner's injury. *See,* AX1.

Petitioner testified that he has worked as a route service representative for Aramark for almost ten (10) years. He works in the Franklin Park area, selling and delivering floor mats, towels, and uniforms. He has two children, ages 12 and 17.

On February 26, 2013, he was driving a step van, which is similar to a UPS van. The step to enter and/or exit the van is about one and one-half (1-1/2) feet higher than the step into an automobile. He enters and exits the van approximately forty (40) times per shift. At about 7:00 a.m. he was stepping out of the van, planted his foot, and felt pain in his right knee. He had had no prior injuries to or symptoms in his knee. He testified that he had not had any prior treatment to his right knee. He hobbled throughout the day. When he finished working, he told the district manager. He worked with assistance on February 27, 2013; and at the end of the day, he was sent to Concentra.

Petitioner provided a history at Concentra that he slipped, twisting, and injuring his right knee, while stepping out of a truck. Petitioner reported hearing a popping sound and located the pain on the medial joint line and patellar tendon. The physician at Concentra, Dr. Osama Thanlij, diagnosed a sprain/strain of the right knee, ordered physical therapy and light duty. PXA.

Aramark accommodated the light duty by giving the petitioner a filing assignment. He was not working the route. The parties agree that Petitioner sustained a temporary wage loss while working light duty; and received the appropriate amount of TPD.

Petitioner followed-up at Concentra for the next three weeks. He testified that he attended physical therapy and at some point, an MRI was prescribed. It is his understanding that the MRI revealed a torn meniscus. He was referred to an orthopedist. PXA.

A friend had recommended Dr. Jimenez at Illinois Bone & Joint Institute therefore; petitioner chose to see Dr. Jimenez. Petitioner first presented to Dr. Jimenez on April 2, 2013 and provided a consistent history of accident. Dr. Jimenez noted the MRI showed a partial, medial meniscal tear. He diagnosed a torn medial meniscus and recommended surgery. PXB.

Dr. Jimenez performed an arthroscopic partial medial meniscectomy on April 15, 2013. Following surgery, Petitioner attended physical therapy at AthletiCo. On April 23, 2013, Dr. Jimenez recommended Petitioner continue physical therapy and remain off work. PXB.

At the Respondent's request, Petitioner attended an independent medical evaluation ("IME") with Dr. Lawrence Lieber, on May 22, 2013. After reviewing medical records and examining Petitioner, Dr. Lieber concluded that Petitioner needed no additional treatment and was able to return to work in a full duty capacity. RX1.

Dr. Jimenez disagreed and kept Petitioner off work until June 11, 2013. Effective June 11, 2013 Dr. Jimenez permitted Petitioner to return to light duty. Petitioner followed the advice of Dr. Jimenez, stayed off work and continued to attend physical therapy. On or about June 25, 2013 Dr. Jimenez released Petitioner to return to work in a full duty capacity. PXB.

Petitioner testified that the extra month of physical therapy resulted in improvement in his condition. On cross-examination Petitioner agreed that he does not know how he would have progressed if he did not attend the extra month of physical therapy.

On May 20, 2013, Petitioner told the physical therapist that he had been increasing his activities and had started jogging. Petitioner rated his pain at 4/10 to 8/10. Petitioner reported improvement on the dates of May 21 and May 28, 2013, respectively and on May 30, 2013, told the therapist that he did not feel prepared to return to work. PXC.

Petitioner returned to work on June 26, 2013 and has worked in a full duty capacity, since that date.

Currently, he feels pain while using stairs and entering/exiting his truck. At home, he uses Ibuprofen and ice. He can no longer play basketball with his children.

He returned to Dr. Jimenez on January 21, 2014 for the first time since June 2013. Dr. Jimenez administered a shot, but Dr. Jimenez spoke about a future knee replacement. Petitioner plans to delay the knee replacement as long as possible.

Petitioner attended a second examination with Dr. Lieber on October 23, 2013. Dr. Lieber's examination found full range of motion and some tenderness. Petitioner completed a lower limb questionnaire. He concluded that Petitioner sustained a 2% functional impairment of the right lower extremity pursuant to the AMA Guidelines. RX2.

Conclusions of Law

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

It is within the province of the Commission to determine the factual issues, to decide the weight to be given to the evidence and the reasonable inferences to be drawn there from; and to assess the credibility of witnesses. *See, Marathon Oil Co. v. Industrial Comm'n*, 203 Ill. App. 3d 809, 815-16 (1990). And it is the province of the Commission to decide questions of fact and causation; to judge the credibility of witnesses and to resolve conflicting medical evidence. *See, Steve Foley Cadillac v. Industrial Comm'n*, 283 Ill. App. 3d 607, 610 (1998).

It is established law that at hearing, it is the employee's burden to establish the elements of his claim by a preponderance of credible evidence. *See, Illinois Bell Tel. Co. v. Industrial Comm'n.*, 265 Ill. App. 3d 681; 638 N.E. 2d 307 (1st Dist. 1994). This includes the issue of whether Petitioner's current state of ill-being is causally related to the alleged work accident. *Id.* A claimant must prove causal connection by evidence from which inferences can be fairly and reasonably drawn. *See, Caterpillar Tractor Co. v. Industrial Comm'n.*, 83 Ill. 2d 213; 414 N.E. 2d 740 (1980). Also, causal connection can be inferred. Proof of an employee's state of good health prior to the time of injury and the change immediately following the injury is competent as tending to establish that the impaired condition was due to the injury. *See, Westinghouse Electric Co. v. Industrial Comm'n*, 64 Ill. 2d 244, 356 N.E.2d 28 (1976). Furthermore, a causal connection between work duties and a condition may be established by a chain of events including Petitioner's ability to perform the duties before the date of the accident and inability to perform the same duties following that date. *See, Darling v. Industrial Comm'n*, 176 Ill.App.3d 186, 193 (1986).

Petitioner sustained a twisting injury to his right knee that resulted in a torn medial meniscus. Petitioner had surgery and attended physical therapy. Dr. Jimenez and Dr. Lieber agree that Petitioner's right knee condition is related to the accident. Therefore, the Arbitrator finds Petitioner's condition of ill-being is related to the accident.

K. What TTD benefits are in dispute?

Petitioner's lost time commenced on April 15, 2013; i.e., the date of surgery. Petitioner lost time through June 25, 2013. TTD was paid through May 22, 2013; i.e., the date of Dr. Lieber's IME. The issue is whether Petitioner was able to work full duty between May 23 and June 25, 2013.

Dr. Lieber concluded Petitioner was able to work full duty. According to the AthletiCo records, Petitioner was able to jog during this period and reported consistent improvement. However, his treating doctor, Dr. Jimenez did not agree and kept him off work, in a full duty capacity, until June 25, 2013. Petitioner followed his doctor's advice and did not attempt to return to full duty work until

June 25, 2013. The Arbitrator finds Dr. Jimenez' opinions to be more persuasive than those of Dr. Lieber. The Arbitrator concludes that Petitioner has established that he was entitled to TTD between May 23 and June 25, 2013.

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

Petitioner attended a second examination with Dr. Lieber on October 23, 2013. Dr. Lieber's examination found full range of motion and some tenderness. Petitioner completed a lower limb questionnaire. He concluded that Petitioner sustained a 2% functional impairment of the right lower extremity pursuant to the AMA Guidelines.

Pursuant to Section 8.1b of the Illinois Workers' Compensation Act, 820 ILCS 305/1 *et seq.* (hereinafter the "Act"), for accidental injuries that occur on or after September 1, 2011, permanent partial disability shall be established using the following criteria:

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

(b) In determining the level of permanent partial disability, the Commission shall base its determination on the following factors: (i) the reported level of impairment pursuant to subsection (a); (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. No single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as report by the physician must be explained in a written order.

With respect to Section 8.1(b)(i), Dr. Lieber assessed a PPI rating of 2% functional impairment of the right lower extremity. No other physician offered an assessment of Petitioner's impairment, pursuant to the AMA Guidelines. While the Arbitrator places some weight on this factor, the Arbitrator finds and concludes that the functional impairment assessment, performed by Dr. Lieber, is woefully lacking, pursuant to Section 8.1b of the Act. The doctor's report should have included an evaluation of medically defined and professionally appropriate measurements of impairment, including, but 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.

With respect to Section 8.1(b)(ii), Petitioner's occupation, he works as a route salesman and has returned to work and continues to work in a full duty capacity, albeit with some pain. The Arbitrator places some weight on this factor.

With respect to Section 8.1(b)(iii), Petitioner's age, 43, suggests that Petitioner is in the middle of his work life.

With respect to Section 8.1(b)(iv), Petitioner's future earning capacity, there is no evidence that Petitioner will sustain future wage loss. Petitioner mentioned that he will need future surgery, and he told Dr. Jimenez that he is concerned about his ability to continue to work. Any earning capacity is speculative at this time and there is no evidence of a future wage loss.

With respect to Section 8.1(b)(v), evidence of disability corroborated by Petitioner's treating records, Petitioner has been working without restriction. He has continued complaints that he associates with arising from a chair, walking long distances and using stairs and other daily acitivites. The Arbitrator places some weight on this factor.

The Arbitrator finds that Petitioner has sustained a 20% loss of use of the right leg.

15IWCC0023

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
13WC11119
SIGNATURE PAGE

Signature of Arbitrator

April 8 2014
Date of Decision

APR 8 – 2014

STATE OF ILLINOIS)
) SS.
COUNTY OF KANE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

HARRIS, KEITH,
Petitioner,

vs.

15IWCC0024

NO: 12 WC 44404

Fed Ex Freight, Inc.,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 11, 2014 is hereby affirmed and adopted.

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

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

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

DATED: JAN 12 2015
KWL/vf
O-1/6/15
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

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

15IWCC0024

HARRIS, KEITH
Employee/Petitioner

Case# **12WC044404**

FED EX FREIGHT INC
Employer/Respondent

On 2/11/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.11% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0455 SAFANDA LAW FIRM
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111 E SIDE DR
GENEVA, IL 60134-2402

1401 SCOPELITIS GARVIN LIGHT ET AL
GREGORY E AHERN
30 W MONROE ST SUITE 600
CHICAGO, IL 60603

STATE OF ILLINOIS)
)SS.
COUNTY OF Kane)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

15IWCC0024

KEITH HARRIS
Employee/Petitioner

v.

FED EX FREIGHT, INC.
Employer/Respondent

Case # 12 WC 44404

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **George Andros**, Arbitrator of the Commission, in the city of **Geneva**, on **December 9, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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 _____

15IWCC0024

FINDINGS

On the date of accident, **August 20, 2012**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$53,476.50**; the average weekly wage was **$1,028.22**.

On the date of accident, Petitioner was **37** years of age, ***single*** with **3** dependent children.

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

Respondent shall be given a credit of **$20,000.00** for TTD, $ for TPD, $ for maintenance, and $ for other benefits, for a total credit of **$20,000.00**.

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

ORDER

The Arbitrator denies the claim for temporary total disability.

The Arbitrator also denies the request for future medical treatment including a shoulder surgery.

The Arbitrator denied the claim for penalties and attorneys 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 party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

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

/s/ George Andros
Signature of Arbitrator

February 7th, 2014
Date

FEB 11 2014

Keith L. Harris v. Fed Ex Freight Corp. 12 WC 44404

Did An Accident Occur That Arose Out Of And In the Course Of Petitioner's Employment By The Respondent?

Mr. Harris testified that on August 20, 2012 he was at a meeting at Fed Ex regarding some events at work the previous week. Present at this meeting were Mr. Harris, Mr. Robert Vander Heide, a person named Joe and a person named Kevin. They were in some sort of managerial position with Respondent. Outside of the meeting was a David Mills, who was also in a supervisory capacity over Mr. Harris.

Mr. Harris denied that this was a disciplinary meeting. Further he was in and out of the meeting on several occasions. On one occasion he was on the dock asserting at the hearing he made a cell phone call on his personal cell phone to the Respondent human relations department. At that exact time, another supervisor yel

led at him, he turned simultaneously thus tripping over the blades of a forklift truck.

Mr. Harris said blades were approximately just under knee height and he tripped over them. Pictures were admitted as PX 5 representing to be in the condition of the forklift on August 12th. That picture shows the height at a different level. He fell on his right shoulder, knee and right hand by his testimony.

Petitioner testified Kevin came over there. Somehow the Petitioner felt Kevin did not believe that he fell as it appeared and did not actually believe him when he originally fell. Shortly thereafter he was taken by ambulance to the Provena Medical Center.

The Arbitrator finds based upon the preponderance of the evidence he sustained accidental injuries arising out of and in the course and scope of his employment on August 20, 2012.

Were The Medical Services That Were Provided To Petitioner Reasonable And Necessary? Has The Respondent Paid All Appropriate Charges For All Reasonable And Necessary Medical Services?

The records of the Provena Mercy Medical Center (P. EX. 2) show history that Mr. Harris tripped over a forklift, pulled his groin, and landed on his right shoulder and knee. He also had some complaints in the heel. X-rays showed a normal examination of the right hip, negative examination of the right foot, negative AP and lateral x-ray of the right knee without evidence of fracture or effusion or degenerative changes. An x-ray of the right shoulder was described as normal, while x-ray of the middle finger of the right hand showed a subtle hairline lucency involving the base of the middle phalanx of the third digit- suspicious for subtle fracture.

A report for services on August 23, 2012 by Dr. Charles Woodward, showed multiple contusions secondary to the fall, a right shoulder contusion, and a right middle finger fracture. The records further reveal that as of a visit on August 20th, he was released to return to work with restrictions as to lifting, pushing, and climbing of ladders. MRI performed on January 22, 2013by interpretive report showed a partial, with full thickness tear at the anterior edge of the supraspinatus tendon that measured about 1.5 centimeters in width.

Noting the time gap - he had no treatment until December 7, 2012, when he was examined by Dr. Abdul Qadir. Doctor recorded consideration for a possible rotator cuff injury followed by MRI on January 22, 2013. There is no indication in these records of a prior MRI, as testified to by Mr. Harris. Also, he prescribed Motrin/Ibuprofen for pain as necessary. Importantly, there is nothing in these records, or in the earlier records, to indicate that any narcotic prescription had been prescribed this petitioner.

Petitioner thereafter was examined by Dr. Jamil Jacobs-El on February 4, 2013. Dr. Jacobs-El recommended surgery on the tear of the rotator cuff as described in the MRI. Notably, nothing in these records document medical prescription for any narcotic medication. In fact, Dr. Jacobs-El records indicated that Mr. Harris told him he "takes medication for pain minimally at this time". (P. Ex. 1)

Dr. Jacobs-El testified he did recommend the surgery yet admitted the in the area of the small tear, as described by the MRI, many people do not need surgery for that; Further, he indicated that doctors have disagreed about recommended treatment. The doctor was very non-committal on many of his medical answers in terms of being supportive of the patient's medical-legal issues. This doctor has an exemplary medical training based upon deposition exhibit one.

Dr. Preston Wolin performed a section 12 examination at the request of Fed Ex Freight, Inc. Dr. Wolin concluded that the small tear could be as a result of the episode of August 20, 2012, either by aggravation or the accident itself could have been a cause of the small tear. Dr. Wolin would not do surgery on Mr. Harris based on what he described by testimony and reports as symptom magnification; His symptom magnification would mitigate any good result from such surgery being performed. Further, the surgery would not be necessary due to the small size of the tear. Dr. Wolin was adamant in his medical opinion. Dr. Preston Wolin's opinion is given great weight in the case at bar.

Petitioner admitted three medical bills (P. Ex. 8), a bill from the City of Aurora for the ambulance from Fed Ex to the Provena Medical Center on August 20, 2012, in the amount of $401.40 (P. Ex 9), a bill from Provena Mercy Medical Center with charges and credits and it appears that there is a balance of $2,655.22, due Provena Medical Center on these charges. Px. #3 from Aurora Radiology Consultants, shows a balance due of $340.00.

The Arbitrator finds as a matter of fact and law these bills are reasonable and necessary and causally related to the accident of August 20, 2012.The Respondent is ordered to pay directly to the providers pursuant to the Fee Schedule, the amounts due on these total charges of $3,036.62.

Is The Petitioner's Current Condition Of Ill-Being Related To The Injury? And What if any temporary total disability is due?

Mr. Harris seems to have made herculean efforts in linear fashion to create evidence for litigation while the aforementioned events took place to wit; taking the pictures taken of the forklift immediately after the occurrence, taking pictures taken of himself at the hospital, and his arm (P. Ex. 6A, 6B), yet asserting these were not for purposes of litigation. The question in the air about the reason for meeting, the petitioner's testimony/creation of a supervisor's questioning of the accident itself moments after the petitioner fall plus the clear opinion of Dr. Preston Wolin regarding symptom magnification all enter the determination of the preponderance of the evidence.

There is the issue of temporary total disability benefits, for which Mr. Harris is claiming benefits on August 29, 2012 through December 9, 2013 totaling 68-1/7 weeks. The Respondent has disputed that he is entitled to any benefits; The workers' testimony stands he returned to work a day or two after the accident, that he had subsequently received telephone calls from a Mr. Vander Heide on August 23rd telling him to come back to work. As Mr. Harris had testified, he left work because of the pain in his right shoulder. Mr. Vander Heide made another call to Mr. Harris on August 24th and told him if he did not come back to work he would be fired. Mr. Harris had a third call on or about August 29th, when Mr. Vander Heide told him he was fired. This effort by the Respondent to maintain his employment after the accident is a cornerstone of denying TTD , totally supported by Dr. Wolin's other opinion. In the vernacular of the workplace- Petitioner simply skipped out. The Arbitrator deems this job abandonment in relation to the Act and claim for TTD.

The Arbitrator reviewed all of the medical reports submitted on Mr. Harris' behalf and he was given light duty restrictions immediately, and since he returned to work for Fed Ex Freight, Inc. they apparently had work within those restrictions. No doctor after that took Mr. Harris off of work.

When questioned as to why he was not working, he said he was well aware of the regulations in Illinois as to over the road drivers, and if you are taking a medication with a narcotic or codeine in it, then you were not able to drive a truck. This response taken in any light or context eroded his credibility

The Arbitrator makes a finding of material fact that after studying the medical records, there is not one scintilla of evidence on a key medical question of fact to indicate that Mr. Harris was prescribed a narcotic or codeine for this condition. Such medical documentation is a hot button in Illinois and the country and most critical in the transportation industry. When Mr. Harris saw Dr. Qadir in December, the doctor told him to take Motrin or Ibuprofen for pain as necessary. No bar to driving is inferred.

The Arbitrator finds that Mr. Harris' testimony under oath that he has been taking narcotics for the last 16 months is nothing short of fabrication to support litigation. He did not testify as to who allegedly prescribed these narcotics, which is dramatic in and of itself plus even more significant since he indicates that he has been taking them for 16 months. Mr. Harris had no prescriptions, no name of a licensed medical provider registered to prescribe such medication/opiates , no indicia or paperwork from a pharmacy nor even request in the trial stipulation sheet (Request for Hearing) for reimbursement for any of these alleged drugs that he was taking and keeping him from driving let alone any gainful employment.

The Arbitrator therefore finds that Petitioner is not as a matter of fact and as a conclusion of law entitled to temporary totally disability benefits from August 29, 2012 through December 9, 2013, the date of the Hearing.

As to both the issue of TTD and the issue of the claimed need for surgery by the doctor seen months after the incident, the Arbitrator adopts the opinion per the testimony and reports of Dr. Preston Wolin to wit: he would: 1) not recommend surgery for such a small tear; and 2) based on what he described as the complaints or exaggeration of complaints of Mr. Harris, that is not something that he would undertake. His testimony is extremely persuasive in the matter at bar.

The Arbitrator finds as a matter of fact and conclusion of law under section 8(a) that there is no medical necessity need for further surgery. The Petitioner has reached maximum medical improvement i.e. his condition has stabilized. See Manis. Since this case was filed as Section 19(b), the Arbitrator does not reach the issue of what if any permanent partial disability would be ordered.

The Arbitrator finds the Respondent at bar made a good faith challenge at hearing to the payment of compensation. See Avon and Brinkman.

STATE OF ILLINOIS)
) SS.
COUNTY OF DUPAGE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Tammy J. Wyatt,

Petitioner,

vs.

NO: 08 WC 52995

15IWCC0025

Western Distributing Transportation Company,

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

Based on Dr. Candido's opinions, the Commission modifies the Arbitrator's Decision by vacating the wage differential award and finding that Petitioner is permanently disabled to the extent of 25% person as a whole. The Commission also finds that Petitioner was temporarily partially disabled from August 12, 2011 through May 21, 2012, 40-4/7 weeks at $726.00 per week. On May 22, 2012, Petitioner saw Dr. Candido for a §12 evaluation. In his report of that date, Rx1, DepEx2, Dr. Candido noted the July 13, 2007 accident and that Petitioner had sustained a left ankle twist/sprain three months before at her mother's home. He reviewed the medical records of Drs. Kapp, Cleaver and Bowen. He noted Petitioner's school attendance and employment with Southeast Health Center. Dr. Candido noted Petitioner's complaints at that time of pain 4-7/10 at rest, 10/10 with walking or standing for 20 minutes each, sitting was okay, but her leg swells, cold weather, cold tile floors and very hot water like a whirlpool affected her

and she continued to wear a walking boot. He noted Petitioner was able to operate a motor vehicle and drove to all activities. He noted her medications, education and work history. On examination of the left leg, Dr. Candido found no edema or color changes were apparent, no trophic changes and no changes in growth of the hair or nails on either leg or either foot, there was no temperature disparity between her legs and feet, there was no atrophy, there were mild complaints of pain to palpation in the left foot and left ankle, but no allodynia, no hyperalgesia and no hyperpathia. The left ankle was 1cm larger than right ankle. Temperature measurements were the same for both lower extremities.

Dr. Candido indicated that aside from the July 27, 2007 note by Dr. Kapp, there was no mention in any of the provided medical records regarding any ankle fracture. Dr. Candido noted, "It is my interpretation of the records that this is the lone suggestion of a fracture but that this opinion is not corroborated by radiological evidence in favor of this diagnosis." Petitioner reported she did not actually drive after the accident. Dr. Candido noted that there was no evidence by examination of any ongoing ankle sprain or strain. He noted that Petitioner was morbidly obese and had potential for chronic ankle and foot problems. Dr. Candido opined, "While I cannot state with 100% certainty if the Petitioner ever had CRPS, she most assuredly does not have it now, either Type 1 or Type II. She meets none of the diagnostic criteria for this syndrome from any of the major entities or agencies that have developed criteria over the years. In particular, aside from (mild) sensitivity to touch on the lateral aspect of the left ankle and dorsum of the foot, which may be purely subjective, there is no diagnostic assessment, including EMG/NCV studies; MRI studies; bone scan studies; Q-Sweat tests; or other evaluative measures consistent with a diagnosis of CRPS. There is no edema; no color or temperature disparity between the legs or ankles or feet or toes; no trophic changes; no changes in growth of hair or nails; and no atrophy. By standards of acceptability, then, there is nothing to substantiate the CRPS diagnosis in this individual at the time of my examination." Dr. Candido further opined, "If she had CRPS of the ankle or foot at any time, then it has resolved." He opined that it is more likely than not that the ankle sprain at her mother's home three months before July 13, 2007 had not completely healed by the time of her accident. Dr. Candido opined that there was no anatomical or physiological reason why Petitioner would require restrictions. He suggested that a functional capacity evaluation could determine Petitioner's capabilities. Dr. Candido opined that Petitioner would likely not be able to return to work as an over-the-road truck driver while using a continuous administration of opioid analgesics as this posed a liability and risk for her and other motorists. If Petitioner could be weaned off these medications, she would likely be able to return to full unrestricted duty. Dr. Candido opined part-time work was not medically necessary. He noted Petitioner has unresolved pain, but a benign, normal physical examination inconsistent with CRPS or peripheral nerve injury-related pain. He felt medical care should consist of counseling for urgent weight reduction, counseling for ongoing use of potent opioid analgesics, supportive care employing non-narcotic multi-modal analgesic regimens to support the removal of the reliance on opioids as primary pain relieving therapy, a graded process of exercise training/therapy to help Petitioner recruit underutilized and deconditioned muscles. Dr. Candido opined Petitioner is presently at maximum medical improvement for the July 13, 2007 ankle injury.

The Commission notes there is a calculation error in the TTD period. From July 14, 2007 through February 6, 2009 is 82 weeks at $831.00 per week = $68,142.00, not the 86-2/7 weeks awarded. This error is corrected to reflect the TTD period of 82 weeks. The Commission also notes credits to Respondent for amounts paid. Credit for TTD paid by Respondent is $61,133.94 (from July 20, 2007 through February 6, 2009, 81-1/7 weeks at $753.41 per week). Maintenance from February 7, 2009 through August 11, 2011, 130-6/7 weeks at $831.00 per week = $108,742.16. Credit for maintenance paid by Respondent is $96,974.41 (from February 7, 2009 through July 27, 2011, 128-5/7 weeks at $753.41 per week). The Commission affirms all else.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $831.00 per week for a period of 82 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 $831.00 per week for a period of 130-6/7 weeks, that being the period of maintenance under §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $726.00 per week for a period of 40-4/7 weeks, that being the period of temporary partial disability under §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that the wage differential award is hereby vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $636.15 per week for a period of 125 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the permanent disability of the person as a whole to the extent of 25%.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay all reasonable, necessary and related medical expenses under §8(a) of the Act, subject to the Medical Fee Schedule under §8.2 of the Act. Respondent shall have credit for medical expenses paid.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury. The Commission notes that Respondent paid $61,133.94 in TTD benefits and $96,974.41 in maintenance benefits.

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

15IWCC0025

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: JAN 14 2015
MB/maw
o11/13/14
43

Mario Basurto

Stephen J. Mathis

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WYATT, TAMMY
Employee/Petitioner

Case# **08WC052995**

15IWCC0025

WESTERN DISTRIBUTING TRANSPORTATION COMPANY
Employer/Respondent

On 11/22/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.10% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1724 HASSAKIS & HASSAKIS PC
MICHAEL D HASSAKIS
P O BOX 706
MT VERNON, IL 62864

4037 CHRISTINE M ORY PC
511 W WESLEY ST
WHEATON, IL 60187

2965 KEEFE CAMPBELL BIERY & ASSOC LLC
TIMOTHY J O'GORMAN
118 N CLINTON ST SUITE 300
CHICAGO, IL 60661

15IWCC0025

STATE OF ILLINOIS)
) SS.
COUNTY OF DuPage)

☐ 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

Tammy J. Wyatt
Employee/Petitioner

v.

Western Distributing Transportation Company
Employer/Respondent

Case # 08 WC 052995

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 **Carolyn M. Doherty**, Arbitrator of the Commission, in the city of **Wheaton**, on **10/10/13**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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 **Medically-related mileage**

FINDINGS

On **07/13/07**, 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 **$60,713.88**; the average weekly wage was **$1,246.50**.

On the date of accident, Petitioner was **39** years of age, ***single*** with **2** 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 for amounts paid in TTD, maintenance and medical expenses.

Respondent is entitled to a credit of **$0.00** under Section 8(j) of the Act. ARB EX 1

ORDER

Temporary Total Disability Benefits

Respondent shall pay Petitioner temporary total disability of $831.00 per week for a period of 86-2/7 weeks commencing 7/14/07 through 2/6/09 pursuant to Section 8(b) of the Act. Respondent shall receive credit for amounts paid.

Maintenance Benefits

Respondent shall pay Petitioner maintenance benefits of $831.00 per week for a period of 130-6/7 weeks commencing 2/7/09 through 8/11/11. Respondent shall receive credit for amounts paid.

Medical Benefits

Respondent shall pay Petitioner the reasonable and necessary medical services incurred in the care and treatment of the causally related conditions pursuant to Sections 8 and 8.2 of the Act. Respondent shall receive credit for amounts paid.

Wage differential

Respondent shall pay the Petitioner permanent partial disability benefits, commencing August 12, 2011, of $726.00 per 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.

Medically-Related Mileage Expenses

No award is made. SEE DECISION

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

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

Carolyn Doherty
Signature of Arbitrator

11/22/13
Date

NOV 22 2013

FINDINGS OF FACT

Petitioner, a 39 year old truck driver, testified that she began working for Respondent on 7/16/06. Petitioner attended truck driving college and has a background in medical transcription but does not have a college education. Petitioner was hired by Respondent as an armored car driver. She had a CDL went she started for Respondent driving an 18 wheeler box truck hauling high volume loads. Petitioner carried a gun and provided her own security for the truck. Petitioner's responsibilities also included loading and unloading the truck using manual and electric palette jacks. Petitioner testified that she was required to push, lift or carry extremely heavy loads of coin or currency in the course of her duties. Getting in and out of the truck cab required Petitioner to hold the grab bar and climb three steps as the cab was 4 feet off the ground.

Petitioner testified that she drove over 150,000 miles the year before the accident. She was paid between 16.5 and 21.5 cents per mile when she worked for Respondent and $15.00 per hour for guard duty. Petitioner last worked for Respondent in July 2007. She was terminated from her position with Respondent in November 2007. Petitioner testified that driver's currently working for Respondent make 22.5 cents per mile.

Accident and notice are not at issue in this matter. On 7/13/07, Petitioner was in Naperville Illinois on an assigned route. She pulled the truck up on the street in an industrial park and set the truck brakes. Petitioner testified that she stepped out of the truck onto a curb and her left ankle rolled as she stepped down. The accident occurred at 4 am and the lighting was not good at the time. Petitioner's co-driver was sleeping. Petitioner testified that she immediately she felt a pop in her left ankle and tried to shake it off. Petitioner testified that the pain worsened. When she removed her shoe she saw that her ankle was swollen. Petitioner tried to sleep in the truck as her co-driver drove the rest of the route as reflected in the driver's log.

Petitioner never drove a truck thereafter for Respondent. Petitioner kept the foot elevated and iced and sought medical attention in Wisconsin. Petitioner was given crutches and medication and was not to drive for 2 weeks. Petitioner testified that she continued working guard duty on the assigned trip but did not drive the truck. Petitioner was dropped off by her co-driver at home and taken by her husband to Dr. Kapp in Cape Girardeau as directed by Respondent. Petitioner testified that Dr. Kapp initially diagnosed sprains and a fracture and prescribed a cast and crutches. After 4 visits, Dr. Kapp suspected RSD and he sent Petitioner to Dr. Bowen and Dr. Cleaver. Petitioner was sent to these physicians under the direction of a case manager at Genex. Dr. Cleaver and Dr. Bowen administered pain medication including epidural injections, lidocaine, lidoderm patches and an infusion. Petitioner was also sent to physical therapy which she did at Premiere Physical Therapy in Cape Girardeau.

Petitioner adopted Dr. Bowen as her treating physician. On 2/6/09, Dr. Bowen put Petitioner at MMI and continued her on medication for RSD and CRPS, including Cymbalta and Opana with side effects of drowsiness, irritability, and concentration problems. PX 9. Petitioner testified that she did not have these conditions prior to the date of accident. Petitioner is under restrictions for sedentary work, no lifting over 10 pounds, and no climbing. Petitioner was still wearing a walking boot on her left foot at trial. Petitioner testified that on occasion she removes the boot depending on the type of surface she is on. For two years after the accident wore a knee high boot but now wears a boot that is mid calf height.

Dr. Bowen gave a deposition on 7/9/12. PX 1. Dr. Bowen is board certified in physical medicine and rehabilitation with a sub specialty in sports medicine. PX 1, p. 6. In September 2007, Dr. Bowen noted Petitioner's accident and mechanism of injury as well as her initial treatment with Dr. Kapp for the initially diagnosed ankle sprain. PX 1, p. 9. Dr. Kapp referred Petitioner to Dr. Bowen due to Petitioner's continued painful sensitivity following his treatment of the ankle sprain. Dr. Kapp suspected a ligament injury. Petitioner had already received sympathetic nerve blocks from Dr. Cleaver which provided only temporary relief. PX 1, p. 14.

When he initially saw Petitioner he noted allodynia, hypesthesia, color changes, coolness in her foot, decreased range of motion and some associated weakness all on the left foot and ankle. PX 1, p. 15. The symptoms went up the left foot and leg to the middle of the tibia. Petitioner also reported a burning component. PX 1, p. 17. Petitioner was in physical therapy to improve her range of motion. PX 1, p. 18. Petitioner underwent a bone scan which Dr. Bowen concluded was "relatively negative." PX 1, p. 20. Dr. Bowen ran a QSART test for excessive sweating thought to be a small fiber problem. The test was negative. Dr. Bowen never personally saw any pitting edema. Dr. Bowen testified that the "only thing I noted from then on was the color changes episodically in the foot and the coolness." PX 1, p. 25. Dr. Bowen summarized his treatment of Petitioner through 2008 and 2009 testifying that he prescribed oral Lidocaine, Opana and topical pain medications. PX 1, p. 26.

As of 2/6/09, Dr. Bowen decreased the Lyrica, and noted a warm foot, no pitting edema, and allodynia hypesthesis. Petitioner still had problems with flexion with some improvement of her strength. Petitioner was continued on Cymbalta, Lidodaine ointment and methadone. PX 1, p. 29. Petitioner was kept in a walking boot and placed on permanent work restrictions of sedentary work, no lifting greater than 10 pounds and no driving. PX 1, p. 29. Dr. Bowen placed Petitioner at MMI for non-surgical care. PX 1, p. 29. The restrictions remain generally the same today but Petitioner is now able to drive her own private vehicle with an automatic transmission and work a sedentary job. PX 1, p. 30. Petitioner is still wearing the walking boot but Dr. Bowen testified that he would like to see her out of the boot. Dr. Bowen testified that a spinal cord stimulator for pain control is the last option for Petitioner but that she may not be a candidate due to psychological overlay. PX 1, p. 33.

Dr. Bowen's final diagnosis was CRPS type 1 neurogenic pain that is not specific to a particular nerve injury. PX 1, pp. 34-36. His diagnosis was based on the signs of allodynia/hypesthesia, color and temperature changes, and a noted lack of range of motion and strength. Petitioner did not exhibit two other signs sometimes seen including sweating/edema and tropic changes in hair growth or nails. PX 1, p. 37-38. Dr. Bowen opined that Petitioner's CRPS was causally related to her accident and injury of 7/13/07 absent any other history of accident or injury. PX 1, p. 40. Petitioner's ankle sprain led to a chronic problem in the form of CRPS. PX 1, p. 41.

When asked if Petitioner could return to work, Dr. Bowen testified, "Well, at this point in time, I don't think she can, not with her current condition. Again, the biggest problem is her ascending – getting up and down out of a cab and being able to drive a truck with a clutch. … if you had a low to the ground truck and/or she didn't have to clutch, then she could be—the question is with her current medications whether or not that's best. But she's obviously driving POVs, and she has been successful. She hasn't had any accidents. So the presumption is she would do well." PX 1, p. 36. Dr. Bowen expects Petitioner to stay on chronic medication support and the continued use of the boot. PX 1, p. 43. Dr. Bowen opined

that Petitioner met the objective criteria to support the CRPS diagnosis and has no reason to question Petitioner's credibility in the reporting of her subjective complaints. PX 1, p. 49.

On cross-exam, Dr. Bowen testified that as of his visit with Petitioner on 10/25/07, the grade 3 ankle sprain diagnosed by Dr. Kapp had completely resolved and the remaining sole diagnosis was CRPS. PX 1, p. 58. Dr. Bowen respects Respondent's Section 12 physician Dr. Graham, but does not agree with his opinion that Petitioner does not suffer from RSD. PX 1, p. 60-62. Dr. Bowen testified that in his opinion, a patient does not have to present every single objective criteria for a diagnosis of CRPS to be made. PX 1, p. 65. Dr. Bowen was asked for an explanation of why Petitioner could tolerate wearing a boot for years but could not tolerate wearing a tight sock on her foot. He testified that "...it kind of goes along with the desensitization thing that we talked about before. She didn't tolerate anything tight on there like a sock, but for some reason the looseness of the boot gives her enough protection in the sense that she's not moving her ankle. So she doesn't have the nauseous stimulus of moving her ankle. She also doesn't have the wind or the things hitting up against it and she does seem to tolerate that well. ... now can I explain why that and not the sock? No I can't really. ... it's not the first time that I've seen that where somebody finally finds something that they can wear." PX1, p. 76.

Dr. Bowen also reviewed the Section 12 report from Dr. Candido. Dr. Bowen noted that Dr. Candido used a temperature strip to measure temperature differences in Petitioner's feet and ankles. The temperature was the same. Photos taken by Dr. Candido show no discoloration of the feet, no abnormal hair or nail growth, no signs of atrophy, and no tropic changes. PX 1, pp. 77- 79. Dr. Bowen testified that he saw nothing in the photos to support a diagnosis of CRPS. He further testified that he has seen Petitioner in his own office with her feet in a similar condition to the photos and that the objective signs will wax and wane as is not unusual in CRPS patients. PX 1, p. 80. He agreed that Petitioner looked to be doing well after her visit to Dr. Candido. In his opinion, Petitioner will need maintenance treatment with medications to limit her pain levels every three months for potentially the rest of her life. A pain stimulator is the last non-surgical option, provided the trial stimulator helped her condition. Dr. Bowen has never doubted Petitioner's veracity or his desire to return to her job driving a truck. PX 1, p. 91.

Petitioner was seen by three Section 12 experts. First, Petitioner was seen by Dr. John Graham at the Pain Treatment Centers on June 18, 2008. RX 3. Dr. Graham authored an addendum report dated July 14, 2008. RX 4. Dr. Graham is an anesthesiologist in St. Louis, MO. Dr. Graham diagnosed left foot dysesthetic pain, primarily described on the medial and dorsal aspect of the foot from the first metatarsophalangeal joint traveling medial up through the ankle up to the lower leg. He indicated she did not have global dysesthetic pain in the foot as would be expected in an RSD patient. Dr. Graham indicated he did not agree with the diagnosis of complex regional pain syndrome as Petitioner did not exhibit 8 or more of the 11 objective criteria used to diagnose CRPS. Dr. Graham opined that allodynia is not an objective sign but rather a subjective complaint. He recommended bilateral lower extremity nerve conduction studies to compare the left lower extremity with the unaffected right as well as a left MRI. RX 3. Dr. Graham ordered these studies to determine other possible causes for Petitioner's complaints such as irritation of the superficial peroneal and saphenous nerve or soft tissue injury to the ankle. Such studies were performed and later reviewed by Dr. Graham.

On July 14, 2008 Dr. Graham modified his opinion following the results of the nerve conduction studies and the MRI of the left ankle. He opined there was at present "no neurologic finding that would account for the patient's subjective complaints." He recommended Petitioner be placed at MMI and she be weaned

off all medications. He indicated Petitioner could use OTC anti-inflammatories and reiterated he believed there was no medical finding preventing a return to full duty work at Respondent. RX 4.

On 10/13/08, Petitioner was seen by Dr. John Krause, a board-certified orthopedic surgeon who provided deposition testimony taken February 27, 2013. Dr. Krause testified he reviewed the same x-rays of the foot and ankle Dr. Kapp reviewed. Dr. Krause saw no evidence of fracture. He opined that he fully agreed with Dr. Graham and could not opine Petitioner suffered from complex regional pain syndrome. RX 2, p. 12. Dr. Krause ordered a bone scan and ultrasound. Such tests were obtained and did not evidence anything abnormal in Petitioner's foot or ankle. RX 2, p. 13. Dr. Krause indicated these diagnostic results did not change his opinion that Petitioner did not suffer from CRPS. RX 2, p. 14. The Arbitrator notes the x-rays, EMG/NCV, bone scan and ultrasound of Petitioner's foot and ankle were normal. On cross-exam Dr. Krause agreed that the symptoms of CRPS wax and wane and that a patient could have symptoms one day and not the next. RX 2, p. 25, 29. In so testifying, Dr. Krause was asked, "… you would agree that wouldn't mean that she would not have it based on a diagnosis by observation on a single day because she could have had other evidence of the problem in future other visits…" and in response he stated, "Right, I can't say what she was like the day before or the day after. I can just say the day I saw her she didn't have it and the day Dr. Graham saw her didn't have it." RX 2, p. 29. When he saw Petitioner on 10/13/08 she did not exhibit objective signs of CRPS in his opinion.

Lastly, Petitioner was seen by Dr. Kenneth Candido who is board-certified in pain management and who saw Petitioner on 5/22/12. Dr. Candido provided deposition testimony taken June 18, 2013. Dr. Candido testified to the scientific history and background of CRPS and the objective and subjective criteria that are used to diagnose such a condition. Dr. Candido testified to the manner in which he collected evidence from his examination of Petitioner's feet, ankles and legs to observe tropic, edemic and temperature changes of her foot and ankle. He confirmed he observed no measurable changes of any kind. Dr. Candido further explained he did not observe any evidence of allodynia. Dr. Candido confirmed there was no objective confirmation of a fracture ever being present other than the one comment in the medical record generated by Dr. Kapp—he did not feel the x-rays supported Dr. Kapp's comment. Dr. Candido testified he observed no subjective or objective criteria with which to diagnose Petitioner with CRPS on the one occasion he observed Petitioner. RX 1, pp16-27, 72. Dr. Candido testified it was his medical and scientific opinion that Petitioner did not have CRPS in that "she met none of the criteria that are proposed and promulgated … by authorities on complex regional pain syndrome to be the most accurate and most representative of the syndrome." RX 1, p. 27. He further testified that she "might have had" CRPS before she saw him but by the time she saw him any CRPS she might have had had resolved. RX 1, p. 27. Finally, Dr. Candido testified that in his opinion, the objective signs of CRPS do not wax and wane. RX 1, p. 59. Symptoms can wax and wane but not objective findings. Dr. Candido acknowledged that Dr. Bowen repeatedly commented on the objective signs and symptoms that he observed during his visits with Petitioner. RX 1, p. 61.

Dr. Candido was asked "Can you agree, Doctor, that his incident in the course of work as related to you on the history was at least a factor contributing to her injuries?" Dr. Candido answered, "yes." RX 1, p. 64.

Petitioner testified that currently she has a burning sensation like scalding water down her left leg. Some days the sensation is worse than others. Petitioner testified that if she her ankle will bother her if she steps on hot or cold surfaces and with weather changes. Some days she has not problems at all. The burning

and swelling worsens with any period of standing, extended walking or over exertion. Her left foot has a cold feeling and is purplish color. She has a great amount of swelling into her calf area which occurs based on her activity level and the discoloration on the top of her foot and ankle area comes and goes.

Petitioner also testified to weakness in the left ankle and that her ankle has a tendency to roll even while wearing the boot. Petitioner must then return to crutches. Petitioner testified that the medication helps with the symptoms but the side effects are severe. Petitioner wears an elevated gym shoe on the right foot with an orthotic for support. Finally, she testified that she does not live like she did before this accident in that her ankle condition prohibits her from being active. She no longer plays sports, dances or goes boating.

Petitioner testified that 3 months before this accident she rolled her left ankle causing the ankle to swell in a non-work related accident. However, the x-rays were negative and Petitioner continued to drive for work with no medical follow up.

Petitioner has performed her own job search for the period of February 2009 up through February 2012. PX 10. Petitioner returned to business college and took medical billing classes from September 2009 through November 2010. Petitioner took the classes through the state of Missouri and drove with a friend to school. Specifically, Petitioner testified that the school was 57 mile each way from her home. Petitioner drove ¼ of the way on her own, picked up her friend and then her friend drove Petitioner's car the rest of the way. Petitioner can drive an automatic vehicle but is restricted from driving a clutch vehicle.

Petitioner currently works in medical coding 14 hours per week. Petitioner testified that she was hired to work 14-hours, 2 days per week as it is the maximum number of hours her doctors will allow her to work. Petitioner earns $11.25 per hour and continues to look for a better paying job.

A vocational assessment report was prepared by Encore dated 9/26/11 following a meeting with Petitioner on 8/29/11. RX 5. Petitioner permanent physical restrictions per Dr. Bowen were noted as sedentary work, no climbing, and must wear a boot. Petitioner has an Associate's degree in medical coding and billing which she obtained in December 2010 after her return to school. Petitioner is a certified coder. Petitioner reported that she is proficient with a computer and is able to actively search for work on the internet. Petitioner attends interviews and the part time job she had at the time of her assessment was the result of her most recent interview. Petitioner reported that she continues to look for medical coding jobs within her sedentary limits but with pay comparable to her pay as a truck driver. Petitioner would like to return to work as a truck driver but knows that it is not possible. Petitioner reported extensive job experience in many areas including secretarial work and administrative work for several companies. RX 5.

A transferable skills analysis indicated that Petitioner could perform the sedentary work of an administrative assistant, cashier, customer service rep, and clerk. Petitioner also has a CDL and a FOID card along with reliable transportation and the ability to drive. It was noted that Petitioner lives in an area of Missouri with a small population and a limited job market. However, it was further noted that Petitioner then currently had a temporary job with Missouri Southern Healthcare which was noted by the Consultant as being the major employer in Petitioner's area. RX 5.

The date of the addendum vocational report is not apparent but it was issued after the consultant was advised that the IME doctor's returned Petitioner to full duty work. The Consultant concluded that with some requested accommodation, Petitioner's job possibilities included truck driving in addition to the prior jobs mentioned in the first report. RX 6.

Petitioner testified that she or her husband would drive to her doctor appointments 50 to 60 miles one way. Petitioner treated with Drs. Bowen and Cleaver in Cape Girardeau as there are only 2 family doctors located where she lives in Puxaco Missouri. She does not live in close proximity to an orthopedic or a physiatrist.

CONCLUSIONS OF LAW

The above findings of fact are incorporated into the following conclusions of law.

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

Petitioner's current condition of ill-being is CRPS as diagnosed by her treating physician Dr. Bowen. As agreed by all physicians who examined and treated Petitioner, Petitioner's initial ankle injury has resolved. The physicians are divided over the diagnosis of CRPS. The Arbitrator finds that Petitioner's current condition of ill-being, CRPS, is causally related to the accident and injury of 7/13/07. In finding causal connection for Petitioner's CRPS, the Arbitrator notes she is cognizant of the lingering controversial nature of a CRPS diagnosis in both the medical and legal communities, despite its steady presence and dissection in both communities for several years. However, the fact that a diagnosis is controversial does not compel the conclusion that a claimant is incapable of proving a causal connection. In the instant matter, the Arbitrator finds sufficient evidence to support a finding of causal connection for Petitioner's CRPS based on Petitioner's state of good health prior to the accident, the dramatic change in condition following the accident, the medical evidence proffered by Petitioner's treating physician and on Petitioner's own credible testimony at trial.

The Arbitrator first notes that Petitioner as in good health and capable of driving an 18 wheeler on long routes requiring heavy labor prior to her injury. Petitioner credibly testified that she enjoyed her job for Respondent. Petitioner was not under any active medical treatment for her left ankle or foot or for CRPS prior to or at the time of this accident and was able to work and conduct daily activities without problem. It is uncontested that Petitioner rolled her ankle getting off the truck on 7/13/07 and Petitioner credibly testified to the details of her accident. The Arbitrator further notes that Petitioner testified in a candid and focused manner regarding the deterioration of her abilities following the work accident. Petitioner's testimony is buttressed by her treating medical records documenting the deterioration of her condition from ankle sprain to RSD and then to CRPS and her physicians' attempts to identify and control her condition.

The finding of causal connection for CRPS is further supported by the testimony of her treating physician, Dr. Bowen. The Arbitrator notes that the opinions of all physicians involved, both treating and examining, were very credible. However, in light of Petitioner's continued subjective complaints and objective signs presented to and documented by Dr. Bowen on several visits over the course of several years, the Arbitrator assigns greater weight to the opinions of Dr. Bowen on the diagnosis of CRPS.

Dr. Bowen's final diagnosis was CRPS type 1 neurogenic pain that is not specific to a particular nerve injury. PX 1, pp. 34-36. His diagnosis was based on the signs of allodynia/hypesthesia, color and temperature changes, and a noted lack of range of motion and strength. Petitioner did not exhibit two other signs sometimes seen including sweating/edema and tropic changes in hair growth or nails. PX 1, p. 37-38. Dr. Bowen opined that Petitioner's CRPS was causally related to her accident and injury of 7/13/07 absent any other history of accident or injury. PX 1, p. 40. Dr. Bowen testified that the objective signs of CRPS can wax and wane and did so in Petitioner's case. While he testified that symptoms not objective signs, can wax and wane, Dr. Candido further testified that Petitioner "might have had" CRPS before she saw him but not on the one occasion he saw Petitioner and that by the time she saw him "...any CRPS she might have had had resolved." RX 1, p. 27, 59. Dr. Candido acknowledged that Dr. Bowen repeatedly commented on the objective signs and symptoms that he observed during his visits with Petitioner. RX 1, p. 61. Finally, Dr. Candido was asked "Can you agree, Doctor, that his incident in the course of work as related to you on the history was at least a factor contributing to her injuries?" Dr. Candido answered, "yes." RX 1, p. 64. The Arbitrator further notes that Dr. Krause agreed that the symptoms of CRPS wax and wane and that a patient could have symptoms one day and not the next. RX 2, p. 25, 29. Dr. Graham opined that Petitioner showed no objective criteria for CRPS on the one day he saw Petitioner. Accordingly, based on Dr. Bowen's opinion combined with the credible presentation of Petitioner at trial and reflected in the medical records, the Arbitrator finds causal connection for Petitioner's CRPS condition of ill-being.

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

Respondent's objection on the issue of medical care and expenses was based on liability. ARB EX 1. Accordingly, based on the Arbitrator's findings on the issue of causal connection, the Arbitrator further finds Respondent shall pay Petitioner's reasonable and necessary medical expenses incurred in the care and treatment of her causally related condition pursuant to Sections 8 and 8.2 of the Act. Respondent shall receive credit for amounts paid. ARB EX1.

K. What temporary benefits are in dispute? TTD/Maintenance

Respondent's objection to the payment of TTD and maintenance was again based on liability. ARB EX 1. Accordingly, based on the Arbitrator's findings on the issue of causal connection, the Arbitrator further finds Respondent shall pay Petitioner temporary total disability for a period of 86-2/7 weeks commencing 7/14/07 through 2/6/09 pursuant to Section 8(b) of the Act. Respondent shall receive credit for amounts paid. ARB EX 1. Further, the Arbitrator finds that Respondent shall pay Petitioner maintenance following the MMI finding of Dr. Bowen and the start of her medical coder job for the period of 130-6/7 weeks commencing 2/7/09 through 8/11/11 during which time Petitioner conducted her self directed job search. PX 10. Respondent shall receive credit for amounts paid. ARB EX 1.

Petitioner's average weekly wage was stipulated at trial. ARB EX 1. Petitioner's AWW was $1,246.50 with a corresponding TTD/maintenance rate of $831.00 and a PPD rate of $636.15, the maximum rate allowed for the date of accident.

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

At trial, Petitioner requested an award under Section 8(d)(1) of the Act. Based on the record in its entirety, the Arbitrator finds that Petitioner is entitled to a wage differential under Section 8(d)(1) of the Act having been incapacitated from pursuing her usual and customary line of employment. Based on the foregoing findings and on the restrictions of sedentary work with no climbing of stairs and no driving a clutch vehicle as set forth by Dr. Bowen, Petitioner is unable to return to her job driving an 18 wheeler.

The Arbitrator further finds that Petitioner is working at suitable employment as a medical coder within her sedentary restrictions. Petitioner earns $11.25 per hour working 2 days per week 7 hours per day. PX 12. Petitioner testified that the job was part time when she was hired and that she continued to look for a higher paying job without success. PX 10. Petitioner continued to work two days per week per Dr. Bowen who on 4/8/13 noted "she notes that she has also been forgetting things and has been confused and this has been going on awhile since 2011 prior to being on Opana she says. At times it is hard to concentrate and focus. She is having trouble with coding at work. She is only working two days a week because she notes that when she is working the two days a week she has to take more of the Opana when she is home. She only has to take a 5 mg. If she works it is as much as a 15 mg with some break through pain as well so she has only been working 2 days a week and that is all that she can tolerate." PX 2. As a result, Dr. Bowen noted, "I am going to recommend at this time that she work no more than 2 days a week because of the discomfort that it causes her and that is about all that she can tolerate." PX 2.

Based on the stipulated AWW of $1,246.50 and Petitioner's earnings of $157.50 per week ($11.25 per hour x 14 hours per week), Petitioner's wage differential is $1089.00 x 66-2/3 = $726.00 per week for the duration of the disability because of the work injuries sustained on July 13 2007, and all as provided in Section 8(d)1 of the Act.

O. Other – medical mileage

As stated in General Tire & Rubber Co. v. Industrial Com'n, 221 Ill.App.3d 641 (5th Dist. 1991), it is proper to award mileage expenses to a Petitioner for travel to medical appointments in excess of 100 mils when the travel was not unreasonable. General Tire & Rubber Co., 221 Ill.App.3d at 651. In this case, local treatment where Petitioner lived was not available. Petitioner testified and Respondent did not dispute that the closest orthopedic doctors and physiatrist to Petitioner's home in Puxico, Missouri were located in Cape Girardeau, Missouri. Petitioner further testified that Respondent's agent made all of Petitioner's medical arrangements including those for her physical therapy treatment at Premier Rehab in Cape Girardeau, Missouri. Respondent also did not offer any evidence showing that local treatment, akin to the care given by Petitioner's medical providers, was available to Petitioner.

Although the Arbitrator finds that it was reasonable for Petitioner to treat with Drs. Kapp, Bowen, and Cleaver at their attendant and referred facilities, there is no evidence in the record of actual mileage amounts incurred by Petitioner for each visit other than testimony that the round trip visits exceeded 100 miles. There is no doubt Petitioner attended these visits as supported by the medical record of each visit but there are no receipts provided showing mileage incurred. The Arbitrator finds there is an insufficient record on which to award medical travel expenses.

STATE OF ILLINOIS)
) SS.
COUNTY OF DUPAGE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Karen Trzos,
Petitioner,

vs.

NO: 07 WC 031407

Harlem Furniture,
Respondent.

15IWCC0026

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of causation, necessity of current medical expenses, temporary total disability, permanent disability, §8(j) credit, application of the doctrine of res judicata and intervening accident and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof with the exception of the notations below.

Pursuant to §19(b) of the Illinois Workers' Compensation Act, this claim was initially heard by Arbitrator Erbacci on June 15, 2009 and a decision was issued on July 14, 2009. At the conclusion of the §19(b) hearing, Arbitrator Erbacci provided a causation statement that Petitioner's current condition of ill-being is causally connected to the May 25, 2007 work accident. While Respondent appealed the case and the §19(b) transcript was authenticated, Respondent subsequently dismissed the appeal and the Arbitrator's decision became final. As a result of Respondent's actions, the authenticated §19(b) transcript became part of the file.

The case was subsequently heard by Arbitrator O'Malley and a decision was issued on March 18, 2014. In his decision, Arbitrator O'Malley found Petitioner failed to prove her alleged headaches and/or cervical spine condition are causally connect to the May 25, 2007 work accident. The Arbitrator based his decision on the fact that Petitioner's original injury report did not mention headaches as one of the injures. He also found that regardless of what Petitioner complained of and regardless of whether her complaints of neck pain can be equated somehow to a headache, no medical opinion was offered to relate the headache/cervical complaints to the May 25, 2007 work accident. Arbitrator O'Malley found that Arbitrator Erbacci's finding of causation in the prior §19(b) hearing was limited to Petitioner's lumbar spine and cocygeal

injuries. He noted that while Petitioner did testify as to intermittent headaches, there was nothing in the medical opinions that relates these headaches back to May 25, 2007 accident. He further concluded that since the prior §19(b) decision did not directly address the issue of causation with respect to the alleged headaches, the doctrines of res judicata and collateral estoppels do not apply. He then allowed evidence regarding Petitioner's alleged headaches and cervical condition to be placed into the record. Lastly, he found that Petitioner failed to prove her alleged headaches and cervical condition are causally related to the May 25, 2007 work accident.

The Commission has original jurisdiction and is charged with the responsibility of reviewing the entire file. As the §19(b) transcript along with Arbitrator Erbacci's decision is part of the file the Commission reviewed the same along with the remaining evidence to determine if the application of res judicata and collateral estoppels apply or whether the doctrine of law of the case applies to the claim.

As previously noted, at the conclusion of the §19(b) hearing, Arbitrator Erbacci provided a causation statement that Petitioner's current condition of ill-being is causally connected to the May 25, 2007 accident. The Commission finds that the issues before it are whether or not Arbitrator Erbacci found that the alleged headaches and/or cervical condition are/are not causally related to the May 25, 2007 accident and whether or not a ruling on this issue was made by him. Additionally, whether or not Arbitrator O'Malley's holding that, the doctrines of res judicata and collateral estoppels do not apply is proper.

A review of the records shows that unfortunately, Arbitrator Erbacci did not provide a ruling that specifies what, of the multiple body parts claimed, are causally connected to the May 25, 2007 accident. Looking at the totality of his analysis, the Commission finds that it is readily apparent that Arbitrator Erbacci specifically found that Petitioner's low back and cocygeal injuries are causally related to the May 25, 2007 accident and he provided a specific basis for his findings by citing to the doctors' opinions. Where this analysis falters is that while he addresses Petitioner's testimony regarding her multiple complaints and while he lists what those complaints were, he then provided a generic causation opinion without addressing the relationship of these complaints to the work accident. Based on the "generic" conclusion given, the Commission finds that Arbitrator O'Malley's use of the terms res judicata and collateral estoppels is in error and the proper term is law of the case.

The rule of law of the case is a rule of practice, based on sound policy that, where an issue once litigated and decided, that should be the end of the matter and the un-reversed decision of a question of law or fact made during the course of litigation settles that question for all subsequent stages of the suit. The principles underlying the law-of-the case doctrine apply to all matters resolved in proceedings before the Commission. See Weyer v. Workers Compensation Commission, 387 Ill. App. 3d 297, 307 and Irizarry v. Industrial Commission, 337 Ill. App. 3d 598, 606-607. In applying the principles of law of the case to the facts in this case, the Commission finds it was not bound by the Arbitrator's Erbacci's earlier decision and more specifically his finding of causation. Arbitrator Erbacci at best set forth a generic causation statement, which did not specifically address Petitioner's headache/cervical condition. As such the Commission finds that neither Arbitrator O'Malley in the subsequent arbitration hearing nor the Commission on review are bound by Arbitrator Erbacci's earlier decision.

15IWCC0026

Having reviewed the totality of the file, the Commission finds that, with the exception of changing Arbitrator O'Malley's use of terms res judicata/collateral estoppal, the Commission formally adopts the Arbitrator's findings of facts and conclusions of law and affirms the Arbitrator O'Malley's decision. The Commission finds that while Petitioner's attorney set forth a request for specific findings in his brief, three of the four requests are statements and not in the proper form and, given the Commission's ruling, the fourth is moot and need not be addressed.

IT IS THEREFORE ORDERED BY THE COMMISSION that with the exception noted above the Decision of the Arbitrator filed March 18, 2014 is hereby affirmed and adopted.

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

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

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

DATED: JAN 14 2015

MB/jm

O: 12/4/14

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Mario Basurto

David L. Gore

Stephen Mathis

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

TRZOS, KAREN
Employee/Petitioner

Case# **07WC031407**

15IWCC0026

HARLEM FURNITURE
Employer/Respondent

On 07/14/2009, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.27% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2004 LAW OFFICES OF JEROME SCHACHTER
RICHARD DOMASH
9933 N LAWLER SUITE 100
SKOKIE, IL 60777

4234 RIPES NELSON BAGGOT KALOBRATSO
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HOFFMAN ESTATES, IL 60169

15IWCC0026

STATE OF ILLINOIS)
)
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
19(b) ARBITRATION DECISION

Karen Trzos
Employee/Petitioner

Case # 07 WC 31407

v.

Wheaton

Harlem Furniture
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Anthony C. Erbacci**, arbitrator of the Commission, in the city of **Wheaton**, on **June 15, 2009**. After reviewing all of the evidence presented, the arbitrator hereby makes findings on the disputed issues checked and in bold below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was the respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of the petitioner's employment by the respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to the respondent?
F. ☒ Is the petitioner's present condition of ill-being causally related to the injury?
G. ☒ What were the petitioner's earnings?
H. ☐ What was the petitioner's age at the time of the accident?
I. ☐ What was the petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to petitioner reasonable and necessary?
K. ☒ What amount of compensation is due for temporary total disability?
L. ☐ Should penalties or fees be imposed upon the respondent?
M. ☐ Is the respondent due any credit?
N. ☒ Other - Prospective medical treatment.

15IWCC0026

FINDINGS

- On May 25, 2007, the respondent Harlem Furniture *was* operating under and subject to the provisions of the Act.
- On this date, an employee-employer relationship *did* exist between the petitioner and respondent.
- On this date, the petitioner *did* sustain injuries that arose out of and in the course of employment.
- Timely notice of this accident *was* given to the respondent.
- In the year preceding the injury, the petitioner earned $ 19,423.80 ; the average weekly wage was $ 373.54 .
- At the time of injury, the petitioner was 43 years of age, *single* with no children under 18.
- Necessary medical services *have not* been provided by the respondent.
- To date, $ 9,321.97 has been paid by the respondent for TTD and/or maintenance benefits and $ 2,241.24 has been paid by the respondent as an advance of permanent partial disability benefits.
- To date, $ 174,859.99 has been paid by the respondent for medical expenses through its group medical plan for which it is entitled to credit under Section 8(j) of the Act.

ORDER

- The respondent shall pay the petitioner temporary total disability benefits of $ 249.03 /week for 101 3/7weeks, from May 26, 2007 through December 12, 2007 and from January 23, 2008 through June 15, 2009 , as provided in Section 8(b) of the Act, because the injuries sustained caused the disabling condition of the petitioner, the disabling condition is temporary and has not yet reached a permanent condition, pursuant to Section 19(b) of the Act.
- The respondent shall, subject to the medical fee schedule contained in the Act, pay $ 95,958.93 for medical services and shall authorize and pay for the spinal chord stimulator trial prescribed by Dr. Malek, as provided in Section 8(a) of the Act.
- The respondent shall pay $ 0.00 in penalties, as provided in Sections 19(k) and 19(l)of the Act.
- The respondent shall pay $ 0.00 in attorneys' fees, as provided in Section 16 of the Act.
- In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of temporary total disability, medical benefits, or compensation for a permanent disability, if any.

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

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

Arbitrator Anthony C. Erbacci

July 8, 2009
Date

JUL 14 2009

In support of the Arbitrator's Decision relating to (F), Is the Petitioner's present condition of ill-being causally related to the injury, the Arbitrator finds the following:

The Petitioner sustained an undisputed accidental injury while working for the Respondent on May 25, 2007 when she tripped over a pallet and fell backwards onto her buttocks. She continued working and later the same day reported the accident to her supervisor.

On May 26, 2007, the Petitioner sought medical treatment at LaGrange Memorial Hospital. She underwent a MRI of the lumbar spine that was reported to reveal degenerative discs and facet arthropathy throughout the lumbar spine, a small central disk extrusion at L2-3, a transitional lumbar segment at S1, mild right L5-S1 neural foraminal narrowing and no evidence of lumbar fracture. The Petitioner was then seen on May 29, 2007at Edward Hospital Occupational Health on referral from the Respondent. She was examined and received x-rays. She was taken off work and prescribed physical therapy which she attended until June 25, 2007. On July 3, 2007 the Petitioner saw Dr. Lang at Edwards Clinic, and more physical therapy was prescribed.

On July 13, 2007 the Petitioner saw her family physician, Dr. Dhawan who referred her to an orthopedic surgeon, Dr. Salehi. On August 17, 2007, the Petitioner was seen by Dr. Sean A. Salehi. Dr. Salehi reviewed Petitioner's lumbar x-rays and opined that they revealed evidence of significant disk height loss at L1-L2 with osteophyte formation and retrolisthesis at L2-3. He reviewed Petitioner's lumbar MRI and opined that it revealed a central disk herniation at L2-3 without neural compression and moderate thoracolumbar junction kyphosis. Dr. Salehi diagnosed the Petitioner with a muscle strain and coccygeal pain and he prescribed an additional course of physical therapy which the Petitioner underwent from August 27, 2007 through December 14, 2007.

On December 10, 2007, the Petitioner was seen and examined by Dr. Babak Lami at the request of the Respondent. The deposition testimony of Dr. Lami was obtained on April 13, 2009 and was admitted into the record as Respondent's exhibit 6. Dr. Lami testified as to the Petitioner's complaints and exam findings and he opined that her MRI and x-ray findings revealed a degenerative condition not unusual for someone her age. He further opined that her symptoms were out of proportion to the physical findings. Dr. Lami opined that the Petitioner sustained a tailbone contusion and perhaps a lumbar sprain as a result of the May 25, 2007 accident. He further opined that the Petitioner was not a candidate for epidural injections or surgery and that she was capable of returning to her previous job without limitations.

Following Dr. Lami's exam, the Petitioner returned to work for the Respondent on December 13, 2007. The Petitioner continued to work light duty for the Respondent until until January 22, 2008. During this period, the Petitioner continued to see Dr. Salehi and he recommended she undergo a spinal fusion in her low back.

On January 28, 2008, the Petitioner underwent a diskectomy and fusion of L1-L3

performed by Dr. Salehi. The postoperative diagnosis was L1-2 and L2-3 degenerative disk disease. Prior to the surgery Dr. Salehi referred Petitioner to Dr. Alborno for treatment of her coccydenia. He performed tailbone blocks on January 24, 2008, April 10, 2008 and May 14, 2008.

Dr. Lami authored a second report dated April 8, 2008 following his review of additional records. Dr. Lami testified, that the surgery performed on the Petitioner was not necessary regardless of the causation of her condition. He opined that the Petitioner had degenerative disc changes at several levels and that her clinical symptoms did not correspond to the L1, L2, L3 level. He further opined that there was no evidence of instability and that it was not in the Petitioner's best interest to have surgery.

After the fusion the Petitioner followed up with Dr. Salehi and she underwent a course of physical therapy from February 28, 2008 to May 1, 2008. On July 8, 2008, Dr. Salehi ordered a functional capacity evaluation which was not authorized or performed. Dr. Salehi then referred Petitioner to another surgeon, Dr. Phillips. On August 1, 2008 Dr. Phillips recommended a discogram, which was not authorized or performed.

Dr. Lami authored a third report dated March 10, 2009 following his review of additional records. Dr. Lami testified his previous opinions were not altered and he opined that the Petitioner had reached maximum medical improvement by the time of his initial examination. Finally, Dr. Lami opined that the Petitioner was not a candidate for a spinal cord stimulator. He testified that spinal cord stimulators are used to treat neuropathic pain but Petitioner had pain on the tailbone when you push on it and therefore this would be "off label use."

The deposition of Dr. Sean Salehi was obtained on May 8, 2009 and was admitted into the record as Petitioner's exhibit 27. Dr. Salehi testified that the Petitioner had significant degenerative disk disease at L1-2 and L2-3 and significant restrolisthesis at L2 over L3. He opined that the Petitioner's degenerative changes of the lumbar spine and restrolisthesis pre-existed the work accident but that she became symptomatic following the work accident. Dr. Salehi testified that the surgery was performed to correct Petitioner's unstable spine or retrolisthesis and degenerative disk disease of L1-2 and L2-3. Dr. Salehi opined that the Petitioner's condition and need for surgery were causally related to the Petitioner's work injury. Dr. Salehi testified that he last treated the Petitioner on July 8, 2008 and that x-rays performed at that time revealed a solid fusion. He further testified that the Petitioner was not capable of working at that time.

On August 1, 2008, the Petitioner was seen by Dr. Frank M. Philips at Midwest Orthopedics on referral from Dr. Salehi. Dr. Philips reviewed Petitioner's x-rays and confirmed the previous fusion was healing. He opined Petitioner had advanced disk degeneration with collapse and sclerosis at L5-S1 and further opined this might be her prominent pain generator. He opined Petitioner's tailbone pain was a separate issue and unlikely to be relieved by any surgical intervention. He believed this should be treated symptomatically.

On November 20, 2008, the Petitioner saw Dr. Michel Malek, a physician of her own choosing. The deposition of Dr. Malek was obtained on February 25, 2009 and was admitted

into the record as Petitioner's exhibit 26. Dr. Malek testified that he performed three epidural injections and coccygeal blocks that resulted in partial improvement of Petitioner's symptoms. Dr. Malek opined that the Petitioner's surgery of January 28, 2008 was causally related to the work accident and that her coccygeal pain is, likewise causally related to the work accident. Dr. Malek testified that the Petitioner requires a spinal cord stimulation trial and, if that is not successful, then further surgery may be necessary. He testified that the Petitioner was not capable of returning to work.

The Petitioner testified she was last seen by Dr. Malek on February 12, 2009. She further testified that from the May 25, 2007 accident to the January 28, 2008 fusion surgery and through the present, she has had constant pain in her tailbone, low back, and mid-back, and intermittent headaches. She testified that she can only sit for 30 minutes, stand for 30 minutes, drive for a similar period, and is unable to sleep through the night. The Petitioner testified that, with the exception of injuring her tailbone during childbirth twenty years prior, she had no back pain or problems prior to her work injury on May 25, 2007.

Based upon the opinions of the Petitioner's treating physicians, Dr. Salehi and Dr. Malek, as well as the testimony of the Petitioner, the Arbitrator finds that the Petitioner's present condition of ill-being is causally related to the work injury of May 25, 2007. The Arbitrator specifically finds the testimony and opinions of Dr. Salehi and Dr. Malek to be more persuasive than the testimony and opinions of Dr. Lami.

In support of the Arbitrator's Decision relating to (G), What were the Petitioner's earnings, the Arbitrator finds the following:

The Petitioner alleged an average weekly wage of $400.00. The Respondent alleged an average weekly wage of $373.54. The Respondent submitted into evidence a wage statement which demonstrated that the Petitioner's regular earnings for the fifty-two weeks prior to the accident were $19,423.80. The Petitioner testified that she was paid at the rate of $10.00 per hour and that she generally worked forty hours per week plus overtime. The Petitioner testified that her overtime hours were voluntary.

Based upon the wage statement admitted into the record without objection, the Arbitrator finds that the Petitioner's earnings in the year preceding the injury were $19,423.80 and that the average weekly wage is $373.54.

In support of the Arbitrator's Decision relating to (J), Were the medical services that were provide to Petitioner reasonable and necessary, and (N.), Prospective medical treatment, the Arbitrator finds the following:

The Petitioner submitted evidence of $270,817.92 in total medical bills. The parties stipulated that Respondent is entitled to credit for $174,859.99 for the bills that were paid by the Petitioner's group insurance carrier. Based upon the Arbitrator's findings and conclusions relating to the issue of casual relation, which are adopted and incorporated herein, the

Arbitrator finds that the medical services provided to the Petitioner were reasonable, necessary and causally related to the injury of May 25, 2007. Therefore Petitioner is, subject to the amounts allowable under the medical fee schedule, awarded $95,958.93, which represents the difference between the total bills and the amount paid by the group carrier.

The Petitioner's treating physician, Dr. Malek, has prescribed a spinal chord stimulator trial which includes a psychological evaluation component. Based upon the Arbitrator's findings and conclusions relating to the issue of casual relation, which are adopted and incorporated herein, the Arbitrator finds that the spinal chord stimulator trial which includes a psychological evaluation component prescribed by Dr. Malek is reasonable and necessary medical care for the Petitioner.

In support of the Arbitrator's Decision relating to (K), What amount of compensation is due for temporary total disability?, the Arbitrator finds the following:

The Respondent stipulated that the Petitioner was temporarily totally disabled from May 26, 2007 through December 10, 2007 and the parties agreed that the Respondent paid Temporary Total Disability benefits during that period. The Petitioner was off work during that period at the prescription of her treating physicians. The Petitioner testified she returned to work for the Respondent on December 13, 2007 and continued working until January 22, 2008. It is not clear from the evidence presented that any physician specifically took the Petitioner off work on that date, although the Petitioner had been seeing Dr. Salehi since August 17, 2007. On January 28, 2008 Dr. Salehi performed surgery on the Petitioner consisting of a fusion at L-1, L-2. The Petitioner has remained off work since that time and has not been authorized to return to work by any of her treating physicians. Dr. Salehi indicated that, as of the last time he saw the Petitioner on July 8, 2008, the Petitioner was unable to work. Dr. Malek first saw the Petitioner on November 20, 2008 and he also opined that the Petitioner was unable to work.

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

TRZOS, KAREN
Employee/Petitioner

Case# **07WC031407**

15IWCC0026

HARLEM FURNITURE
Employer/Respondent

On 3/18/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

2004 JEROME SCHACHTER & ASSOC
RICHARD DOMASH
9933 N LAWLER SUITE 100
SKOKIE, IL 60077

2999 LITCHFIELD CAVO LLP
ROBERT G LAMMIE
303 W MADISON ST SUITE 300
CHICAGO, IL 60606-3309

15IWCC0026

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

Karen Trzos,
Employee/Petitioner

v.

Harlem Furniture,
Employer/Respondent

Case # **07** WC **31407**

Consolidated cases: **none**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Peter M. O'Malley**, Arbitrator of the Commission, in the city of **Wheaton**, on **November 15, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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 _____

15IWCC0026

FINDINGS

On **5/25/07**, 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 conditions of ill-being with respect to her lower back, tailbone and left arm/hand ***are*** causally related to the accident, but that her current conditions of ill-being with respect to her head and neck ***are not*** causally related to the accident.

In the year preceding the injury, Petitioner earned **$19,423.80**; the average weekly wage was **$373.54**.

On the date of accident, Petitioner was **51** 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 **$76,381.06** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$2,500.00** for other benefits, for a total credit of **$78,881.06**. (Arb.Ex.#1).

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 $ 249.03 per week for 142-6/7 weeks, commencing 6/16/09 through 2/25/13, as provided in §8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from 6/16/09 through 11/15/13, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall be given a credit of $76,381.06 for temporary total disability benefits that have been paid.

Respondent shall pay reasonable and necessary medical services of $156,888.87, as provided in §§8(a) and 8.2 of the Act. Respondent shall be given a credit for medical benefits that have been paid by the group carrier, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in §Section 8(j) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $223.80 per week for 250 weeks, because the injuries sustained caused the 50% loss of the person as a whole, as provided in §8(d)2 of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $23.80 per week for 91.6 weeks, because the injuries sustained caused the loss of use of 20% of the left hand (41 weeks) and 20% of the left arm (50.6 weeks), as provided in §§ 8(e)9 and 8(e)10 of the Act, respectively.

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

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

2/27/14
Date

ICArbDec p. 2

MAR 18 2014

15IWCC0026

STATEMENT OF FACTS:

This case was previously tried before Arbitrator Anthony Erbacci in Wheaton, Illinois on June 15, 2009 pursuant to §19(b) of the Workers' Compensation Act. Arbitrator Erbacci subsequently filed his decision on July 14, 2009. At that time, the Arbitrator determined that Petitioner sustained accidental injuries arising out of and in the course of his employment on May 25, 2007, that Petitioner's condition of ill-being was causally related to said accident, that Petitioner's earnings in the year preceding the injury were $19,423.80 and that the average weekly wage was $373.54, that Petitioner was entitled to reasonable and necessary medical expenses pursuant to §8(a) and the fee schedule provisions of §8.2 of the Act in the amount of $95,958.93 in addition to prospective medical care and treatment in the form of a spinal cord stimulator as well as a psychological evaluation, and that Petitioner was entitled to temporary total disability benefits from May 26, 2007 through December 12, 2007 and from January 23, 2008 through June 15, 2009, for a period of 101-3/7 weeks. (PX2). The Arbitrator's decision was initially reviewed by the Respondent. However, the review was subsequently withdrawn and the decision of the Arbitration became final.

The matter subsequently proceeded to trial on November 15, 2013 on all remaining issues since the time of the original §19(b) hearing on June 15, 2009. At the commencement of trial, counsel for Petitioner, Richard Domash, of Jerome Schachter & Associates, noted that a Petition for Attorney Fees had been filed by a previous attorney on the case. The Arbitrator also notes that while prospective medical treatment was initially listed as an issue in dispute on the Request for Hearing form, counsel for Petitioner subsequently withdrew his request for same on behalf of his client and removed the issue from dispute.

At the hearing held on November 15, 2013, Petitioner testified that she had only worked 1-1/2 to 2 days since the date of the last trial. She indicated that this occurred approximately 1-1/2 to 2 months prior to her testimony in the present matter and that her job entailed talking to people for 8 hours a day conducting a survey. She noted that she made over 200 calls for the time she worked and at the end her head was pounding. She stated that she could not work anymore and ended up in the hospital as a result.

She also testified the burning pain was in the middle of her back where the fusion is located, and that it radiates down into her hips and tailbone. She testified in detail about what she notices about herself as far as activities and limitations. She testified as to the medications she was taking. She is currently taking mostly over-the-counter medications. But she is taking Nortriptyline for headaches and sleeping.

Petitioner testified that she does walk a lot. She indicated that on a good day she can walk a couple of miles with sitting down and stopping. She also noted that she can lift about 25 pounds, but that it hurts even if she lifts 10 pounds.

On May 24, 2011, the Petitioner was involved in another accident. She fell when her hip gave out. She went down, and she broke her left arm. She was walking to the Credit Union in the afternoon. She had two similar falls before that, and more falls since that time. The incident occurred because she "went to take a step and there was nothing there". She had two surgeries on the arm.

Currently, her pain is getting worse. It is getting harder for her to get up in the morning. Her arm, her back, her head – everything – hurts. On a scale of 1 to 10, it is 10 when she gets up, decreasing only to about eight. The left arm throbs every day. She has had pain ever since the day of the accident. She only is able to sleep about three hours at a time on and off.

She indicated that she saw Dr. Rho at the Chicago Rehabilitation Institute. Therapy was recommended. She also saw a psychologist.

Petitioner has been treating with a Dr. Veres. None of the other doctors referred her there. She was looking for a doctor who would accept her insurance.

She currently has headaches all the time. The medication only helps a little bit. A Functional Capacity Evaluation was suggested by Dr. Herman, but was actually prescribed by Dr. Rho. That was done.

As for Dr. Lami, the Petitioner denied that he ever checked her neck, her shoulders, her muscle strength in her arms and legs. She only admitted that he tested her reflexes with a hammer. He did not inspect her back or her tailbone. He never touched her except with the hammer. If he said he did examine those parts of her body that would be a lie.

Petitioner admitted speaking to some people from the Catalyst Return to Work Company. She had an original interview scheduled with them on the phone for July 8, 2013. But she did not start work at that time because of her headaches. The interview was reset for the end of August. Catalyst provided the Petitioner with a handset and phone to work from home. She acknowledged the certified letters showed to her by the Respondent's attorney.

In going over the purported job description with the Petitioner, she denied that the job description was the job she was actually offered. But the various activities she was supposed to do were discussed with her. She did not describe any additional physical activities. She conceded that no doctor ever told her that she could not try to do this job. She could not perform it, however, because of headaches and vision problems. But she claimed that she told "them" that her arm and back were bothering her as well. But she could not recall who they were, or when she talked to "them".

Petitioner admitted that she has never looked for any type of work. She has the equivalent of a high school degree (GED). Other than the prescription for Nortriptyline, she is taking over-the-counter medication, and a "doughnut" to sit on. She was not wearing any braces, slings, or any appliances at the time of trial. She did appear for trial using the cane and she was visibly limping. As for her other falls due to her back, she did not see a doctor or seek medical attention for those.

Again, she testified that she has had headaches since the accident of May 25, 2007. She did not receive any treatment for her head however because they only treated her back. She stated she has been telling people about it, and after the accident happened, they made out a report.

Petitioner was then shown Respondent's Exhibit Number 11, which she filled out in her own handwriting and signed. There was a discussion with the Arbitrator as to whether the Respondent's attorney would be allowed to cross examine with that document since it predates the original hearing. Given the nature of the Petitioner's complaints and allegations, however, limited cross examination was allowed. The report indicates that the Petitioner injured her tailbone, spine, and neck. When confronted that it does not state "head" anywhere in the form, the Petitioner stated that "neck" is part of it.

At the completion of the Petitioner's testimony, the Petitioner called William Baker to testify. The Respondent objected to the witness' testimony. Mr. Baker was allowed to testify as to what he observed in being with the Petitioner on a daily basis. In cross examination, he admitted that he was present with her on the videotapes that were taken. As to the Petitioner's cane, he testified that as far as he knew, she "always had it."

At the request of her attorney, Petitioner was examined on one occasion by Dr. Michael Treister on December 22, 2011 pursuant to §12 of the Act. Dr. Treister testified by way of evidence deposition on June 10, 2013. (PX12).

Petitioner was also examined by Dr. Babak Lami on December 13, 2010 at the request of the Respondent pursuant to §12 of the Act. Dr. Lami testified by way of evidence deposition on March 31, 2011 (RX1) and again on November 6, 2013. (RX2).

The Arbitrator viewed the surveillance footage of Petitioner taken on March 18, 2010, March 27, 2010, September 27, 2012 and September 30, 2012. (RX15). These DVDs generally show Petitioner getting in and out of a white Chrysler mini-van and walking to and from various garage sales and flea markets with her friend, William Baker. Of particular interest are those occasions wherein Petitioner is seen picking up and carrying her grandchild, whom she estimated weighed about 21 pounds at the time. The Arbitrator counted Petitioner picking up this child no less than seven (7) times during the course of the September 27, 2012 surveillance footage, including a period of approximately ten (10) minutes where she is seen standing and holding the child on her left hip, frequently pointing with her opposite hand, presumably at some of the model airplanes in flight, and at one point using her cell phone. She is also seen occasionally repositioning the child by tossing him up and off her hip, all without any apparent difficulty. Petitioner is also seen placing the child in the back seat of the vehicle as well as one instance of bending at the waist and using both arms to help the child up a steep incline. At no time does Petitioner exhibit any outward signs of pain or discomfort while performing any of these activities. Petitioner is also seen bending over at the waist at various times in order to examine items either on the ground or in boxes at the garage sales and flea markets she is seen visiting. In addition, Petitioner is seen carrying plastic grocery bags in both hands on one occasion, at one point even bending and placing the bags on the ground before crossing the street. In another instance, Petitioner is seen assisting Mr. Baker in picking up a case of beer and placing it in the back storage compartment of the minivan. At no time is Petitioner seen exhibiting any outward signs of pain or discomfort, and for the most part appears to walk with a normal gait, albeit at a leisurely pace. Furthermore, while Petitioner claims that her cane was broken at the time, there is no overt sign that she would have needed a cane during the period that she is seen walking in the surveillance footage.

Commenting on the videotape, Petitioner admitted lifting her grandchild as shown in the videos, but claimed that it was the last time she lifted him. She identified her friend Bill Baker who assists her in her activities of daily living and lives with her. He does most of the driving. She lives with her daughter and two grandsons as well.

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

In the prior §19(b) decision, Arbitrator Erbacci determined that "Petitioner's present condition of ill-being is causally related to the work injury of May 25, 2007." (PX2). In making this finding, the Arbitrator found the opinions of Drs. Salehi and Malek to be more persuasive than that offered by Dr. Lami, Respondent's §12 examining physician. (PX2, p.3). Along these lines, Arbitrator Erbacci had previously referred to Dr. Salehi's opinion that "Petitioner's condition (diagnosed post operatively as L1-2 and L2-3 degenerative disk disease) and need for surgery (diskectomy and fusion at L1-L3) were causally related to the Petitioner's work injury." (PX2, p.4). Arbitrator Erbacci had also previously referenced the fact that Dr. Malek had opined that "Petitioner's surgery of January 28, 2008 was causally related to the work accident and that her cocygeal pain is, likewise causally related to the work accident." (PX2, p.3). Thus, it would appear that the Arbitrator's finding of causation was limited to Petitioner's lumbar spine and cocygeal injuries. The Arbitrator notes that while the

prior decision had also referred to Petitioner's complaints of "... constant pain in her tailbone, low back and mid-back, and intermittent headaches..." since the surgery (PX2, p.3), there is no corresponding mention of any medical opinion that would relate these headaches to the accident in question. Therefore, since the previous §19(b) decision did not directly address the issue of causation with respect to these claimed headaches, it stands to reason that the doctrines of res judicata and collateral estoppels do not apply with respect to that issue.

Thus, there would appear to be no question that Petitioner's conditions of ill-being relative to her lumbar spine and coccyx or tailbone are causally related to the accident on May 25, 2007. (PX2). Instead, the question is whether Petitioner's subsequent left arm and/or wrist injury as well as her current headache complaints are causally related to the original injury on May 25, 2007 as well.

With respect to the headaches, Petitioner testified at the hearing held on November 15, 2013 that she has had head pain since the injury on May 25, 2007. She indicated that she told her doctors about it, but later conceded that she did not receive any treatment for same at the time of the original injury. Petitioner testified that her headaches increased about 3 years ago and that they have never gone away. She indicated that presently she has headaches all the time, and that the medication she takes helps a little bit. She also agreed that she left her job conducting telephone surveys after almost two days because of her headaches.

The Arbitrator finds that Petitioner failed to prove that these alleged headaches are causally related to the accident on May 25, 2007. A review of the original accident report clearly indicates that she injured her tailbone, spine, and neck at that time. (RX11). Furthermore, whether or not she reported these headaches at the time of the injury, or even whether her complaints of "neck" pain can somehow be equated with this condition, the fact of the matter is that there is no medical opinion that would relate either the headaches or her neck complaints to the accident in question. Indeed, a thorough reading of the depositions of both Dr. Herman (PX12) and Dr. Treister (PX13) reveal no opinions along these lines. Therefore, Petitioner's claim with respect to her headache and/or neck complaints is hereby denied.

With respect to Petitioner's left arm claim, Ms. Trzos testified that on May 24, 2011 she was walking on the sidewalk to a credit union to deposit money and pay bills when her hip gave out and she fell. She indicated that when she went to take a step it felt like nothing was there, and that she struck the ground with her left wrist. She denied that anything else caused her to fall. Petitioner noted that she had had about two falls before this incident and about five falls after that. She indicated that she did not seek treatment following these incidents given that she only suffered a little bit of bruising as a result.

Following the incident on May 24, 2011, Petitioner visited Palos Community Hospital. (PX4). In an "Emergency Department Physician's Assessment" dated May 24, 2011, Dr. Brian Sullivan recorded a history of back problems, specifically at L1-L2 and L2-L3, and that "[o]ccasionally, her left leg gives out and that is what occurred today. She had a subsequent fall on outstretched hand injuring her left elbow and wrist..." (PX4). Dr. Sullivan's assessment was 1) acute left radial head fracture, 2) acute neropraxia, 3) left wrist injury status post fall, and 4) cervical spinal stenosis. (PX4).

Petitioner was subsequently seen in consultation by Dr. Taruna Madhav Crawford on May 26, 2011. (PX10). In a "History & Physical" recorded on that date, Dr. Crawford noted that Petitioner "does not work secondary to disability from her lumbar spine. She states on May 24, 2011, her 'left hip gave out' and she fell on her outstretched left hand." (PX10). X-rays of the upper extremity revealed a complete comminuted fracture involving the left radial head along with the fracture of the coronoid process of the ulna. (PX4).

Petitioner's §12 examining physician, Dr. Treister, testified that he was of the opinion that "... there was a causal relationship (between the fall in May 2011 and the work injury on May 25, 2007) because she stated that the extremity or the leg gave way and she fell because of ongoing persistent back pain for which there was a reasonable basis on at least two counts. Number one, she had undergone a fusion and had a pseudoarthrosis demonstrated on a CT scan and, number two, she was having persistent cocyodynia or pain in the coccyx." (PX13, pp.16-17).

Respondent's §12 examining physician, Dr. Lami, testified that he did not feel that the fall on May 24, 2011, when her back or hip condition gave out, was caused by the original accident "[b]ecause her diagnostics failed to show any spinal stenosis or anything that compromised the nerves to a degree that caused the fall." (RX2, p.20). In support of this opinion, Dr. Lami pointed out that even Dr. Herman had noted that Petitioner's motor exam was five out of five. (RX2, p.21). However, Dr. Lami went on to agree that since he never examined Petitioner insofar as her arm was concerned he had no opinion along those lines. (RX2, p.21).

Based on the above, and the record taken as a whole, the Arbitrator finds that Petitioner proved by a preponderance of the evidence that a causal relationship exists between the original accident on May 25, 2007 and her ensuing treatment and current complaints relative to her left arm. More to the point, the histories recorded contemporaneously with the fall on May 24, 2011 indicate that Petitioner's left leg and/or hip gave way as a result of her ongoing lumbar spine condition, which itself was causally related to the original accident. Along these lines, the Arbitrator finds the opinion of Dr. Treister to be more persuasive than that offered by Dr Lami, who admittedly did not examine the Petitioner following the May 24, 2011 incident and therefore could not render an opinion with respect to the left arm injury itself.

Therefore, based on the above, and the record taken as a whole, the Arbitrator finds that Petitioner's current conditions of ill-being with respect to her lower back, tailbone and left arm and/or wrist are causally related to the accident on May 25, 2007, but that she failed to prove that her current condition of ill-being with respect to her headaches and/or cervical spine are causally related to same.

WITH RESPECT TO ISSUE (J), WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY AND HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner submitted into evidence unpaid medical bills totaling $156,888.87. (PX1). All of these bills appear to have been incurred as a result of and in conjunction with treatment for Petitioner's left arm injury.

Therefore, based on the above, and in light of the Arbitrator's determination as to causation (issue "F", supra), the Arbitrator finds that Petitioner is entitled to reasonable and necessary medical expenses in the amount of $156,888.87 pursuant to §8(a) and the fee schedule provisions of §8.2 of the Act. The Arbitrator also notes that the parties agreed that Respondent would be entitled to credit for medical expenses made on behalf of Petitioner by the group carrier, and that Respondent shall hold Petitioner harmless for any outstanding bills relating thereto.

WITH RESPECT TO ISSUE (K), WHAT AMOUNT OF COMPENSATION IS DUE FOR TEMPORARY TOTAL DISABILITY AND/OR TEMPORARY PARTIAL DISABILITY, THE ARBITRATOR FINDS AS FOLLOWS:

The original decision by Arbitrator Erbacci had awarded TTD benefits from May 26, 2007 through December 12, 2007 and from January 23, 2008 through June 15, 2009, for a period of 101-3/7 weeks. (PX2). The Arbitrator notes that at the commencement of current proceedings, the parties stipulated that all TTD had been paid through April 10, 2013 and that the amount of these payments totaled $76,381.06. (Arb.Ex.#1).

Respondent's §12 examining physician, Dr. Lami, testified on November 6, 2013. (RX2). At that time, he opined that Petitioner had reached maximum medical improvement ("MMI") as of his examination on December 13, 2010. (RX2, p.19). Dr. Lami noted that Dr. Herman may be correct in terms of a non-union at L2-L3, but disagreed to the extent that another fusion or removal of the coccyx would help Petitioner. (RX2, pp.13-14). As a result, Dr. Lami did not believe that Petitioner was a surgical candidate, and recommended she continue with home exercise program and undergo pain management. (RX2, pp.17-18). Dr. Lami also felt that Petitioner's symptoms appeared out of proportion to her physical findings on examination. (RX2, p.13). Dr. Lami testified that he reviewed the results of a functional capacity evaluation performed on February 25, 2013. (RX2, p.25). Dr. Lami noted that the therapist "felt that the overall testing combination or the clinical observation suggests that considerable questions should be drawn to the reliability and accuracy of Ms. Trzos' report of pain disability. The therapist noted that she demonstrated variable performance throughout the evaluation. She functioned at a sedentary work level; however, due to the inconsistent nature of her performance, this should be considered minimal of her true functional capabilities." (RX2, p.25). Dr. Lami indicated that this means that Petitioner did not give a full effort or that there were inconsistencies in the evaluation. (RX2, p.25). As a result, Dr. Lami felt that Ms. Trzos could function at a medium physical demand level lifting up to 20-30 pounds on a routine basis and up to 50 pounds. (RX2, p.26).

Based on the above, and the record taken as a whole, and in light of what is seen in the video surveillance footage previously discussed (RX15), the Arbitrator finds that Petitioner was temporary totally disabled from June 16, 2009 through February 25, 2013, or the date of the FCE, for a period of 142-6/7 weeks, and that Petitioner failed to prove her entitlement to additional TTD and/or TPD beyond that date. The Arbitrator further notes that the approximately two (2) days that Petitioner worked doing telephone surveys would not be deducted from the TTD period awarded given that it appears to have occurred in July or August of 2013, or subsequent to the period awarded, based upon Petitioner's testimony that she attempted this work in this position approximately 1-1/2 to 2 months prior to her testimony at arbitration.

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

Petitioner is claiming that she is permanently and totally disabled for life pursuant to §8(f) of the Act.

In order to prove entitlement to permanent total disability benefits for life pursuant to §8(f) of the Act, a claimant must prove such a claim either (a) by a preponderance of the medical evidence, (b) by showing a diligent but unsuccessful job search, or (c) by demonstrating that because of his age, training, education, experience and condition no jobs are available to a person in like circumstances. See *ABB C-E Services v. Industrial Commission*, 250 Ill.Dec. 60, 737 N.E.2d 682, 316 Ill.App. 3d 745 (5th Dist. 2000).

An employee is totally and permanently disabled when he is unable to make some contribution to industry sufficient to justify payment of wages to him. *A.M.T.C. of Illinois v. Industrial Commission*, 77 Ill.2d 482, 487 (1979). The employee, however, need not be reduced to total physical incapacity before a permanent total disability award may be granted. *Ceco Corp. v. Industrial Commission*, 95 Ill.2d 278, 286-87 (1983). Rather, the employee must show that he is unable to perform services except those that are so limited in quantity, dependability, or quality that there is no reasonably stable market for them. *Alano v. Industrial Commission*, 282

Ill.App.3d 531, 534 (1996). If the employee's disability is limited in nature so that he is not obviously unemployable, or if there is no medical evidence to support a claim of total disability, he may qualify for "odd lot" status. *Valley Mould & Iron Co. v. Industrial Commission*, 84 Ill.2d 538,546-47 (1981). An odd-lot employee is one who, though not altogether incapacitated to work, is so handicapped that he will not be employed regularly in any well-known branch of the labor market. *Valley Mould*, 84 Ill.2d at 547.

If employees fail to make out a prima facie case that they fall into the "odd lot" category, then it remains incumbent upon them to demonstrate that, given their present condition and in light of their age, training, experience, and education, they are permanently and totally disabled. *ABB C-E Services v. Industrial Commission*, 737 N.E.2d 682, 685, 316 Ill.App.3d 745, ___, 250 Ill.Dec. 60, ___ (Ill.App. 5 Dist. 2000); citing *Valley Mould*, 84 Ill.2d at 547. They may accomplish this by a showing of diligent but unsuccessful attempts to find work or by proof that because of the above mentioned qualities they are unfit to perform any but the most menial tasks for which no stable market exists. *ABB C-E Services*, 737 N.E.2d at 685. Thus, pursuant to the analytical framework set forth in *Valley Mould*, there are three ways by which employees can demonstrate that they are permanently and totally disabled: (1) by a preponderance of the medical evidence, (2) by showing a diligent but unsuccessful job search, or (3) by demonstrating that because of their age, training, education, experience, and condition, no jobs are available to a person in their circumstances. *Id*, at 686.

In the present case, Petitioner admitted that other than working approximately 1-1/2 to 2 days conducting phone surveys she had not sought employment on her own since the previous hearing. In addition, Petitioner has not presented sufficient evidence to the show that no stable labor market exists for her services due to her age, training, education, experience and condition. Along these lines, Petitioner offered no opinion from a vocational rehabilitation counselor or the like to support any claim that no stable labor market exists for her services. Instead, Petitioner's theory of recovery under §8(f) would appear to be based on her claim that she is permanently and totally disabled for life from any and all work based on the medical evidence alone.

In support of her position, Petitioner offered the opinion of her §12 examining physician, Dr. Michael Treister. Dr. Treister testified that he was of the opinion that Petitioner was unable to work as a result of the May 25, 2007 injury. (PX13, p.20). Dr. Treister stated that Petitioner's lumbar pain due to the non-union was enough to deter someone from working, and was an even greater deterrence for an employer to hire her. (PX13, p.22). However, with all due respect to Dr. Treister, the Arbitrator is not fully convinced that he is necessarily in a position to judge how the labor market would view Petitioner from an employability standpoint. Indeed, the position that she was eventually offered, and where she worked all of two days, would appear to have fallen within the restrictions he indicated he would impose upon on Petitioner – namely, no prolonged sitting, repetitive bending or lifting and no assembly type work using her left hand. (PX13, p.45). In fact, Dr. Treister conceded that there may be jobs out there within Petitioner's restrictions, only that he could not think of any. (PX13, p.46). When asked directly about a telemarketing job, Dr. Treister agreed that such a position was a possibility provided Ms. Trzos could sit or stand as needed. (PX13, p.46). Furthermore, the reason Petitioner eventually gave for her in ability to continue in the telephone survey position had nothing to do with any of the conditions that formed the basis of Dr. Treister's opinion, but instead appeared to be due strictly to Petitioner's complaints of headaches. (PX13, p.46).

Dr. Treister also appears to completely discount what is shown in the surveillance tapes. The Arbitrator views these tapes differently. And while they by no means show Petitioner engaging in strenuous activities that would exceed her restrictions, or otherwise call into question her claim for permanent disability, they do show a woman who is not in the kind of severe, debilitating pain that would prevent her from any and all work, even within the restrictions outlined by Dr. Treister. What the surveillance footage shows is a woman doing normal, everyday activities, including the frequent picking up and carrying of a child weighing at least 21 pounds, with

no outward signs or manifestations of pain or discomfort and without the need for a cane to ambulate, in stark contrast to her presentation at arbitration as well as to numerous doctors. As such, while the Arbitrator finds that Petitioner has indeed suffered permanent partial disability as a result of the accident on May 25, 2007, the surveillance video would appear to belie her claims that she is permanently and totally disabled for life from a medical standpoint as a result of her injury. Therefore, the Arbitrator finds that Petitioner failed to prove that she is permanently and totally disabled for life as a result of her injuries pursuant to §8(f) of the Act.

However, as already noted, the evidence does clearly show that Petitioner has suffered serious and permanent disability as a result of this injury. To wit, Petitioner underwent a diskectomy and fusion at L1-L3 on January 28, 2008, a procedure that has been described as a pseudoarthrosis or "failed fusion" due to a non-union at L2-3 as well as ongoing cocygeal pain, in regards to which Dr. Herman had recommended a re-fusion at L2-L3 as well as a coccygectomy, or removal of a portion of the coccyx.

In addition, Petitioner suffered a complete comminuted fracture involving the left radial head along with the fracture of the coronoid process of the ulna following the fall on May 24, 2011. (PX4). She subsequently underwent two surgeries that inserted hardware in both her left elbow and left wrist.

Currently, Petitioner testified tat she notices that the pain in her back is getting worse and that it is getting harder to get up in the morning. She noted that the pain in her back is a "10" on a scale of 1 to 10 when she gets up in the morning and that it decreases to about an "8" after her medication takes effect. She indicated that her pain starts in the middle of her back, above the buttocks and goes into her legs and down to her thighs, but mostly in her left leg. With respect to her left arm, she indicated that it throbs every day and that the pain is a "7", which she claims increases to a "10" during the day.

Based on the above, and the record taken as a whole, as well as the Arbitrator's determination as to causation (issue "F", supra), the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 50% person-as-a-whole pursuant to §8(d)2, as well as 20% loss of use of the left arm under §8(e)10 and 20% loss of use of the left hand pursuant to §8(e)9 of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF WILL)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Cassandra Hervey,

Petitioner,

vs.

NO: 10 WC 48752

15IWCC0027

Catholic Charities,

Respondent.

DECISION AND OPINION ON REVIEW

Petitioner appeals the Decision of Arbitrator Granada finding that Petitioner failed to prove she sustained accidental injuries arising out of and in the course of her employment on December 14, 2010, that all other issues were moot and denied her claim for compensation and medical expenses. The issues on Review are whether Petitioner sustained accidental injuries arising out of and in the course of her employment, whether a causal relationship exists between those injuries and Petitioner's current condition of ill-being and if so, the extent of temporary total disability and the amount of medical expenses. The Commission, after reviewing the entire record, reverses the Decision of the Arbitrator finding that Petitioner sustained accidental injuries arising out of and in the course of her employment on December 14, 2010, that a causal relationship exists between those injuries and Petitioner's current condition of ill-being, that she was temporarily totally disabled from December 15, 2010 through February 8, 2011, a period of 8 weeks, that she is entitled to $11,112.48 in medical expenses, that Respondent is entitled to §8(j) credit of $3,964.64 for payments by Blue Cross and Blue Shield and credit for adjustments by providers of $1,590.96 for the reasons set forth below. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Commission*, 78 Ill.2d 327, 399 N.E.2d 1322 (1980).

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FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission finds:

1. Petitioner, a 34 year old teacher's assistant, testified she has worked for Respondent for almost 15 years (Tr 12). Respondent's office is currently located at 110 Willow in Joliet, IL. In 2010, Respondent was located at 412 E. Benton Street in Joliet, IL (Tr 12-13). At this location, Respondent operated an early childhood development center and taught preschool children (Tr 14). Petitioner became a Teacher's Assistant II in 2007. Before 2010, Petitioner had not ever had any type of injury on her left foot or ankle (Tr 18). She treated with Dr. Patel from June 4, 2008 through August 10, 2012 and she will continue to see Dr. Patel (Tr 27).

On December 14, 2010, Petitioner was working at Respondent's Benton Street location (Tr 39). This was located was on a corner (Tr 40). If her attorney wanted to walk into the building off the street, he could do so. Petitioner parked in the Catholic Charity parking lot. She did not know if Respondent owned the parking lot (Tr 40). Petitioner was given specific instructions on where to park in the parking lot by every supervisor she had at Respondent (Tr 40-41). The parking lot was located on the side of the building (Tr 41). There were certain spots she was told to park in (Tr 41). Petitioner was supposed to park at the further end away from the door. She guessed she was told to park at the further end because of different people that came in and out through the church; there was a handicap sticker there and there were quilters that belonged to the church who were told to park there and Petitioner and others were told to park further (Tr 41-42). Only employees used the area Petitioner parked at (Tr 42). She was not allowed to park anywhere else (Tr 42).

On December 14, 2010, Petitioner got to the parking lot at about 8:00 a.m. Her starting time at work was 8:15 a.m. Petitioner testified, "Got out of my car, walk into the door, fall down, my ankle spins to the back, I fall down out there. An elderly lady that work with, she went back in to get me help. We got me off the floor into the building and into the car and into the emergency room." (Tr 42). Petitioner testified she fell on ice (Tr 42). There is no awning or anything that covers that part of the building (Tr 43). Petitioner did not know how the ice got on the ground. Petitioner testified, "There is on the door on the inside – the parking lot here, the door where we entrance goes here there's a gutter here. There was a gutter up here that was snow, water, rain everything would run down from the gutter right here, right there by the door where we would go in and out." (Tr 43). That is right where Petitioner fell (Tr 43). She was not that far from the door when she fell, about 10 feet (Tr 44). Petitioner injured her left foot and ankle in the fall (Tr 44).

Petitioner went to Silver Cross Hospital emergency room (Tr 44). After that she followed up at Parkview Medical Center and was given a short leg walking cast. It was Petitioner's understanding that she broke her foot and ankle (Tr 45). In January 2011, she underwent a MRI at Provena. Then she was also treating with Dr. George with MK Orthopedics, who put her in a CAM boot (Tr 45). She was referred for physical therapy, which she attended

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at ATI for about 10 visits between April 11, 2011 and May 18, 2011 (Tr 45). Petitioner was asked the following: "Q In that accident you had in December did you hurt your back at all? A The – because there was – because of me having to shift the weight from the foot, yes, it caused pain in my back because I couldn't – there was no balancing the weight. I had to use one side because my ankle was broken." (Tr 46). After the December 14, 2010 accident, Petitioner missed 8 weeks from work from December 15, 2010 through February 8, 2011 (Tr 46). In March 2011, Petitioner was discharged to go back to regular duty regarding her left ankle (Tr 46). She was then referred for more physical therapy, which helped the foot and ankle (Tr 47).

Petitioner testified that she sometimes still has pain and problems with her left foot and ankle (Tr 47). It aches when the seasons change from summer to fall and from fall to winter (Tr 47). Petitioner can modify how she does things. She wears a sleeve over her ankle, she can no longer wear pumps, boots or heels and all her shoes have to be flat, which cannot be cheap and have a cushion (Tr 48). Her foot/ankle swells with severe weather changes (Tr 48). Dr. George ordered the sleeve (Tr 48-49). She was able to do her job (Tr 49). Petitioner received quite a few memos from Respondent regarding parking and where she was allowed to park (Tr 49). The memos were telling her where she could and could not park (Tr 49). She parked where she was told to park (Tr 49). Petitioner did not know if Respondent was responsible for the maintenance and care of that parking lot (Tr 50).

On cross-examination, Petitioner testified that the Benton Street location was the Bethlehem Lutheran Church (Tr 50). As far as she knows, the Bethlehem Lutheran Church owned the parking lot and the church building (Tr 50). She did not know if the Bethlehem Lutheran Church maintained that parking lot (Tr 50-51). Petitioner fell before she started work that day (Tr 51). She had parked in that lot (Tr 51). There were members of the Bethlehem Lutheran Church that would show up there (Tr 51). There were parents of Head Start children that would show up there (Tr 51). They were parked in the various lots, including the one Petitioner was talking about (Tr 51-52). She worked at this site most days (Tr 52). Petitioner could not park on the street because the buses are parked there (Tr 52). She fell in a parking lot before she got inside (Tr 52).

On re-direct examination, Petitioner testified that no one else was allowed in the parking lot other than members of the church or employees of Respondent (Tr 65). The buses are in front of the building. The buses pull up and Petitioner and others go out the door to retrieve the children from the buses to bring them in (Tr 65). If there was parking available in front of the church she could not park there because of the buses (Tr 65-66). On re-cross examination, Petitioner testified that Head Start parents could come in and park in that lot (Tr 66).

2. Silver Cross Hospital records, Px29, indicate Petitioner presented at the emergency room on December 14, 2010 with a contusion, pain, swelling and tenderness affecting the left ankle. The following histories were noted: "Pt was walking on icy sidewalk slipped and fell."; "The problem was sustained on a street or driveway, resulting from the patient falling, from a standing

position." Petitioner was unable to bear weight and was in a wheelchair. It was noted that Petitioner had not experienced similar symptoms in the past. In the X-ray report it was the radiologist's impression that Petitioner had a non-displaced hairline fracture through the distal left fibula. Petitioner was diagnosed with a distal fibula fracture status post fall. A splint was applied to her left calf, left Achilles and left heel using Orthoglass splint applied by technician. It was noted that her pain improved after medications and splinting. Petitioner was discharged home and was to follow up with her primary care physician Dr. Alvi in 2-3 days.

3. Parkview Orthopedic Group records, Px31, indicate Petitioner saw Dr. Semba on December 16, 2010 for a chief complaint of left ankle pain. The following history was noted: "This is a 34-year-old who twisted her ankle and fell. She has a minimally displaced distal fibula fracture. The mortise is intact." On examination, Dr. Semba found that overall, her alignment was okay and her range of motion was not bad. A short-leg walking cast was placed.

4. According to the medical records of the Pain & Spine Institute, Px24, Petitioner saw Dr. Patel on December 22, 2010 for complaints of low back pain and left ankle pain. Dr. Patel noted that Petitioner did very well regarding the RFA for her low back which she had previously, but her left ankle was a major issue now. Petitioner reported that pain radiated to the heel, forefoot and shin and she described the pain as constant, moderate intensity and sharp. The following history was noted: "The precipitating event appears to have been a fall; the actual mechanism of injury was slipped and fell on ice. DOI was December 14, 2010, she fell in the parking lot at work." Dr. Patel noted that Petitioner went to the emergency room and was placed in a temporary splint and sent to Dr. Sembra's office. She had a cast placed by his office and was told to return. Petitioner was requesting a second opinion. Dr. Patel's assessment was low back pain and left ankle pain. Dr. Patel prescribed medications and referred Petitioner to MK Orthopedics to evaluate and treat her. Petitioner was to follow up in 4 weeks.

5. The medical records of MK Orthopedics, Px37, indicate Petitioner saw Dr. George on December 28, 2010 on referral from Dr. Patel for a left ankle fibular fracture. It was noted that Dr. Avi was her primary care physician and Dr. Patel was her pain management physician. Dr. George reviewed intake forms and noted Petitioner had a history of back pain and flat feet. On examination, Dr. George found pain on palpation over the distal fibula with very minimal swelling and there was no instability. X-rays were taken and showed a non-displaced distal transverse fracture, Weber Grade 1, of the left fibula. Dr. George's assessment was a left lateral malleolar fracture, nondisplaced. Petitioner was placed in a CAM boot with weightbearing as tolerated. She was to follow up in 2 weeks.

6. Dr. George ordered a left ankle MRI. According to the medical records of Provena Saint Joseph Medical Center, Px33, Petitioner underwent a left ankle MRI on January 9, 2011. It was the radiologist's impression that the MRI showed: 1) a non-displaced fracture of the distal femoral metaphysis; 2) a small cortical injury along the lateral talar process; 3) injury to the anterior tibiofibular ligament; 4) multifocal or marrow edema contusion was seen within the base of the first and second metatarsal bones as well as in the area of cuneiforms; 5) diffuse soft tissue

circumference of the ankle especially laterally was seen; 6) mild strain of the deltoid ligament, however spring ligament appeared to be intact; 7) subtle area of T2 high signal intensity within distal Achilles tendon, due to mild chronic tendinopathy, however there was no gross rupture of the Achilles tendon seen.

Petitioner saw Dr. George on January 11, 2011. X-rays were taken and showed no further displacement, but there was no obvious healing just yet as the fracture line was still visible. Petitioner was to remain in the CAM boot and follow up in 2 weeks. (Px37).

7. Petitioner reported to Dr. Patel on January 19, 2011 that she was initially better with RFA, however, she had been compensating for the left ankle and she had more lower back pain since her last visit. Petitioner reported this was an aching pain that started on the right that extended over to the left after she had been mobile for some time. Dr. Patel opined that most likely this was related to muscle spasms. Dr. Patel noted Petitioner had been seen by Dr. George since her last visit and was given a brace and boot. Dr. Patel noted that Petitioner would continue to see Dr. George for her ankle. Dr. Patel prescribed medications for low back pain. (Px24).

8. Petitioner saw Dr. George on January 25, 2011. X-rays were taken and showed no visible fracture line compared to the previous x-rays. On examination, Dr. George found very minimal pain on palpation and she was able to walk better. Petitioner was placed in an AirSport ankle brace. She was to follow up in 2 weeks. On his February 8, 2011 examination, Dr. George noted Petitioner had no pain on palpation and had no other complaints. Petitioner reported that she was able to walk without pain. Dr. George indicated Petitioner could transition out of the AirSport ankle brace and return to normal activities. She was to follow up as needed.

Petitioner saw Dr. George on March 1, 2011 and reported she was doing better. Petitioner reported she had no pain, but she was a little bit weak regarding strength and just needed to build up her strength. Dr. George noted she had not been to physical therapy yet. Petitioner reported that she was not able to attend physical therapy at that time due to time constraints. Dr. George discontinued the AirSport ankle brace and continued with the Malleotrain brace. Petitioner was to do activity as tolerated and follow up in one month. (Px37).

9. Petitioner saw Dr. Patel on April 5, 2011 and reported complaints of low back pain and left ankle pain. Petitioner reported she had increased muscle spasms across the whole lower back and into the buttocks. She had more pain the longer she was on her feet. Dr. Patel ordered physical therapy for her low back. Petitioner reported she had been weaned off the ankle brace. Dr. Patel noted, "She seems to compensate a lot for the ankle and since has developed muscle spasms in the lower back." Dr. Patel prescribed medications. (Px24).

10. On April 5, 2011, Dr. George noted that Petitioner reported she was doing well and ambulating in high-top shoes. She still had some residual deep bone pain, but most of her pain she had was coming from her lower back and she was to follow up with Dr. Patel for that. Dr. George noted that Dr. Patel had ordered physical therapy for Petitioner's low back. Dr. George ordered physical therapy for her left ankle and she was to follow up in one month. (Px37).

11. The records from ATI, Px35, indicate Petitioner attended physical therapy from April 11, 2011 through May 18, 2011, when she was discharged. On May 18, 2011, the therapist noted Petitioner was at 80% functional level, her standing tolerance was 3-4 hours, her pain level was 2-3/10, ankle dorsiflexion was 10°, plantar flexion was 44° and her strength was 5/5 in all planes. The therapist recommended a home exercise program.

12. Petitioner presented to Dr. Patel on May 12, 2011 with complaints of low back pain and left ankle pain. Dr. Patel noted Petitioner was attending physical therapy for her low back and left ankle. He noted she was stable on prescribed medications. Petitioner reported she required less medications when she used electrical stimulation at physical therapy. Dr. Patel ordered a TENS Unit so Petitioner could use less medications at home. Petitioner reported physical therapy for her left ankle provided some relief. Dr. Patel prescribed medications.

Petitioner saw Dr. Patel on September 12, 2011 for complaints of low back pain. Dr. Patel noted Petitioner never got the TENS Unit. Petitioner reported her low back pain was slightly worse with the change in weather. She had completed physical therapy for her ankle. Dr. Patel's assessment was low back pain.

On December 13, 2011, Petitioner presented to Dr. Patel with complaints of low back pain and left ankle pain. Petitioner reported she would get flare-ups of low back pain from time to time. Petitioner reported one episode of right lower extremity anterior thigh pain, went to the emergency room and was given medications and discharged. Petitioner reported she still had aching in her left ankle, but felt that it was better overall and dealt with the pain with ice/heat/rest and avoiding high impact. Dr. Patel's assessment was low back pain and left ankle pain and he prescribed medications.

On March 14, 2012, Petitioner reported more low back pain with pain down the bilateral lower extremities to the anterior/lateral thigh. Petitioner reported more pain than in the past and there was no initiating event that made it worse, it just happened on its own. She had no numbness down the legs. Petitioner reported that her left ankle was getting better, but she still had occasional pain and tenderness. Dr. Patel's assessment was the same and he prescribed medications and ordered a lumbar MRI.

On August 10, 2012, Petitioner presented with low back pain, radiation into her right leg and left leg and left ankle pain. Dr. Patel noted that Petitioner did not get a lumbar MRI. Dr. Patel noted Petitioner's symptoms were similar to before and again ordered a lumbar MRI. Dr. Patel's assessment was the same. (Px24).

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13. In his January 9, 2013 deposition, Px26, Dr. Patel testified he is board certified in interventional pain medicine. Dr. Patel recited from his records, noted above. On December 22, 2010, Petitioner indicated that her back was doing well. On January 19, 2011, Petitioner indicated that she had more back pain and that she had an increase in back pain because she was compensating for her left ankle (Dp 23). Dr. Patel opined that basically Petitioner was changing her gait because of her left ankle (Dp 23). Dr. Patel opined the visits on January 19, 2011 and April 5, 2011 were more from the second accident of December 14, 2010 than the June 2007 accident (Dp 23). Dr. Patel opined reasonableness and necessity for the TENS Unit, but did not have an opinion and could not tell whether that was more from the first accident in June 2007 or the second accident December 14, 2010; it would be fair to say that it is at the very least a combination of the two (Dp 24).

On cross-examination, Dr. Patel testified that the treatment he rendered to Petitioner up until her claimed second accident where she hurt her ankle on December 14, 2010 would be related to the June 2007 accident (Dp 45). Dr. Patel opined that any treatment after December 14, 2010 would be related to her December 14, 2010 accident or at least in combination of the two accidents (Dp 45). Dr. Patel would not be able to tell what specifically would be allocated to that second accident of December 14, 2010 (Dp 45).

14. Petitioner's attorney submitted the following medical expenses and they were admitted into evidence:
-Px23: Pain & Spine Institute, Dr. Patel: 1-19-11: Charge: $200.00. BCBS paid: $60.35. Adjustment: $129.00. Balance due: $10.65. 4-5-11: Charge: $200.00. BCBS paid: $60.35. Adjustment: $129.00. Balance due: $10.65.
-Px28: Silver Cross Hospital 12-14-10 ER: Charges: $1,132.95. No payment reflected.
-Px30: Parkview Orthopedic Group, Dr. Semba: 12-16-10: Charges: $1,303.00. BCBS paid: $539.00. Adjustment: $764.00. Balance due: $0.
-Px32: Provena Saint Joseph Medical Center 1-9-11 MRI: Charges: $2,910.60. BCBS paid: $2,341.64. Adjustment: $568.96. Balance due: $0.
-Px34: ATI: PT 4-11-11 through 5-18-11: Charges: $4,182.93. No payment reflected.
-Px36: MK Orthopedics, Dr. George: Charges: $1,183.00. BCBS paid: $963.30. Balance due: $219.70.

The total charges were $11,112.48. BCBS payments total $3,964.64 as reflected on the actual bills. Adjustments by providers total $1,590.96.

Respondent submitted a March 14, 2013 correspondence from BCBS closing the claim. This was admitted into evidence as Rx6.

Based on the record as a whole, the Commission reverses the Decision of the Arbitrator finding that Petitioner sustained accidental injuries arising out of and in the course of her employment on December 14, 2010, that a causal relationship exists between those injuries and

15IWCC0027

Petitioner's current condition of ill-being, that she was temporarily totally disabled from December 15, 2010 through February 8, 2011, a period of 8 weeks, that she is entitled to $11,112.48 in medical expenses, that Respondent is entitled to §8(j) credit of $3,964.64 for payments by Blue Cross and Blue Shield and credit for adjustments by providers of $1,590.96.

When an injury occurs "in an area which is the sole or usual route to the employer's premises, and the route is attendant with a special risk or hazard, the hazard becomes part of the employment." *Bommarito v. Industrial Commission*, 82 Ill.2d at 195, 412 N.E.2d at 550 (1980); *Litchfield Healthcare Center v. Industrial Commission*, 349 Ill.App.3d at 491, 812 N.E.2d at 406 (2004). The Commission finds that Petitioner encountered a special hazard, the ice from an unnatural accumulation from the gutter, slipped and fell while entering the church building where she worked, about 10 feet from the entry door. Although Petitioner did not specifically testify that this was the sole or usual route to the employer's premises, the Commission infers that this was her usual or sole route into the building from her testimony. Based on where Petitioner fell, this is not a parking lot case; it is an entryway case. The case cited by the Arbitrator (*Wal-Mart Stores, Inc. v. Industrial Commission*, 326 Ill.App.3d 438 (2001)) is distinguishable. In *Wal-Mart Stores, Inc.*, the claimant slipped on ice in a parking lot while walking to a friend's car to be picked up on her lunch break; the Appellate Court found that the claimant was not exposed to a risk greater than that of the general public. The Commission also finds that Petitioner encountered the risk of slipping on that ice more than the general public because of the number of times she came into and out of the building to retrieve the children from the buses and bring them inside.

The Commission finds that a causal relationship exists between those injuries Petitioner sustained on December 14, 2010 and her current condition of ill-being, based on the chain of events. The Commission finds Petitioner's average weekly wage was $379.99, based on the stipulation of the parties. The Commission finds Petitioner was temporarily totally disabled from December 15, 2010 through February 8, 2011, when Dr. George released her to return to normal activities. The Commission further finds that Petitioner is entitled to $11,112.48 in medical expenses, that Respondent is entitled to §8(j) credit of $3,964.64 for payments by Blue Cross and Blue Shield and credit for adjustments by providers of $1,590.96. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Commission*, 78 Ill.2d 327, 399 N.E.2d 1322 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $253.32 per week for a period of 8 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act 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.

15IWCC0027

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $11,112.48 for medical expenses under §8(a) of the Act, subject to the Medical Fee Schedule under §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is entitled to a credit in the amount of $3,964.64 under §8(j) of the Act; provided that Respondent shall hold Petitioner harmless from any claims and demands by any providers of the benefits for which Respondent is receiving credit under this order.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury. The Commission notes that Respondent shall have credit for adjustments by providers of $1,590.96.

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

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $7,700.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JAN 14 2015
MB/maw
o12/11/14
43

Mario Basurto

Stephen J. Mathis

David L. Gore

STATE OF ILLINOIS)
) SS.
COUNTY OF KANE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

KEITH LITTLEJOHN,

Petitioner,

vs.

NO: 13 WC 2732

ABF FREIGHT, INC.,

15IWCC0028

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent and Petitioner herein and notice given to all parties, the Commission, after considering the issues of wages, penalties and permanent partial disability (PPD), and being advised of the facts and applicable law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission has considered all of the testimony, exhibits, pleadings and arguments submitted by the parties. Based on the totality of the evidence, the Commission finds that the Petitioner is entitled to penalties of $8,280.00 pursuant to Section 19(l) of the Act for the non-payment of the ATI Physical Therapy (ATI) bill of $1,490.50, which reflects the amount due pursuant to the Fee Schedule.

According to Petitioner's exhibit 5, Petitioner's attorney submitted the outstanding ATI bill to Arkansas Best Corporation (ABC) on February 8, 2013. In a response letter dated February 12, 2013, ABC indicated they were paying bills pursuant to the fee schedule when all documentation has been provided. The Commission notes that the bills were provided to ABC on February 8, 2013. The Commission further notes that the Respondent did not dispute the liability of the bill. The Respondent offered no evidence during the November 14, 2013 Arbitration hearing indicating that the bill has been paid. Therefore, Petitioner is entitled to penalties of $8,280.00 pursuant to Section 19(l) of the Act. The bill has remained unpaid for 276 days,

February 12, 2013 through November 14, 2013. 15IWCC0028

The Commission declines to award penalties pursuant to Section 19(k) and Section 16 of the Act. The Commission notes there was a legitimate dispute as to Petitioner's average weekly wage. Once Petitioner's average weekly wage was confirmed, Respondent issued to Petitioner a check for the temporary total disability shortage.

The Commission further modifies the Decision of the Arbitrator and finds that Petitioner is entitled to receive 17% loss of use person as a whole, pursuant to Section 8(d)2 of the Act. The Commission finds that the Arbitrator provided a thorough analysis of the Petitioner's condition pursuant to Section 8.1(b) of the Act, and relies upon same. However, the Commission believes that additional PPD is required, as Petitioner sustained multiple tears to the ligaments and tendons of the shoulder, requiring repair, as noted in the operative report. The operative report also demonstrates that the Petitioner underwent an excision of the distal clavicle in the left shoulder. Based upon all of these reported repairs, the Commission finds that Petitioner sustained a loss of 17% man as a whole pursuant to Section 8(d)2 of the Act.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on January 27, 2014, is hereby modified as stated above, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $892.99 per week for a period of 13-1/7 weeks, commencing July 18, 2012 through October 17, 2012, 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 temporary partial disability benefits totaling $17,307.41, representing 33-1/7 weeks, March 14, 2012 through July 17, 2012 and October 18, 2012 through February 3, 2013, as provided in Section 8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $695.78 per week for a period of 85 weeks, as provided in §8(d)(2) of the Act, for the reason that the injuries sustained caused the loss of use of 17% of the man-as-a-whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $1,490.50 for medical expenses under §8(a) of the Act. This represents the Fee Schedule amount.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to the Petitioner penalties of $8,280.00 pursuant to Section 19(l) of the Act.

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

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit

15IWCC0028

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 $62,800.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JAN 15 2015

MJB/tdm
O:11/18/14
052

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

LITTLEJOHN, KEITH
Employee/Petitioner

Case# **13WC002732**

ABF FREIGHT INC
Employer/Respondent

15IWCC0028

On 1/27/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.06% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0154 KROL BONGIORNO & GIVEN LTD
CHARLIE GIVEN
120 N LASALLE ST SUITE 1150
CHICAGO, IL 60602

2965 KEEFE CAMPBELL BIERY & ASSOC
TIMOTHY J O'GERMAN
118 N CLINTON ST SUITE 300
CHICAGO, IL 60661

STATE OF ILLINOIS)
)SS.
COUNTY OF KANE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Keith Littlejohn
Employee/Petitioner

v.

ABF Freight, Inc.
Employer/Respondent

Case # **13** WC **2732**

Consolidated cases: _____

15IWCC0028

An *Application for Adjustment 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 **Geneva, Illinois**, on **November 14, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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 _____

15IWCC0028

FINDINGS

On **February 22, 2012**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$76,952.59**; the average weekly wage was **$1,339.48**.

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

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

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

Respondent shall be given a credit of **$11,296.15** for TTD, **$15,694.93** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$26,991.08**.

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 $892.99/week for 13 and 1/7 weeks, commencing July 18, 2012 through October 17, 2012, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner temporary partial disability benefits totaling $17,307.41. Petitioner is entitled to benefits for 33 and 1/7 weeks, for the periods between March 14, 2012 and July 17, 2012 and October 18, 2012 through February 3, 2013, as provided in Section 8(a) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $695.78/week for 75 weeks, because the injuries sustained caused the Petitioner 15% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

Respondent shall pay to Petitioner penalties of $1,662.40, as provided in Section 16 of the Act; $2,770.68, as provided in Section 19(k) of the Act; and $10,000.00, as provided in Section 19(l) of the Act.

Respondent shall pay to Petitioner $1,490.50 for the reasonable and necessary medical services of ATI Physical Therapy, as provided in Section 8(a) of the Act. This is the Fee Schedule amount for the bills submitted in Petitioner's Exhibits 3, 5 and 6.

Respondent shall pay Petitioner compensation that has accrued from February 22, 2012 through November 14, 2013, 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

1/23/14
Date

2

JAN 27 2014

15IWCC0028

FINDINGS OF FACT:

Keith Littlejohn ("Petitioner") is claiming an accidental left shoulder injury on February 22, 2012, while employed with ABF Freight, Inc. ("Respondent") as a Truck Driver-Dock Man. At the time of the accident, Petitioner was 60 years old and had worked for Respondent since February 2, 1990. Petitioner's employment duties include driving a company truck to make deliveries and loading and unloading the truck trailer by hand and forklift. Petitioner is right hand dominant.

Petitioner testified that on the day of his accident, he was unloading a trailer when he released a clip to undo a cross bar that held freight. When he released the clip, the boxes he was standing on gave way, causing Petitioner to stumble. In order to catch himself and not drop the freight, he reached for the trailer wall with his left arm and hand. When he hit the wall he felt a sharp pain in his left shoulder. He was holding the freight on his right shoulder when the accident happened. Timely notice of the accident was given to Respondent.

Petitioner's initial medical treatment was at Dreyer Medical Clinic on March 14, 2012. X-rays of the left shoulder were performed and revealed mild degenerative changes but no acute bony abnormalities. Petitioner was provided with light duty work restrictions of no lifting more than 10 pounds with the left arm. (PX1)

Petitioner was prescribed physical therapy which he began on March 26, 2012 at ATI Physical Therapy. (PX3) On April 12, 2012, Petitioner was re-examined at Dreyer Medical Clinic with little improvement from physical therapy. The doctor prescribed a MRI arthrogram of the left shoulder that was performed on April 17, 2012. The MRI arthrogram revealed: 1.) A tear of the superior labrum extending from anterior to posterior; 2.) Mild tendinosis of the supraspinatus tendon with partial thickness bursal surface tearing; 3.) Mild tendinosis of the subscapularis tendon; 4.) Mild degenerative changes of the posterior and lateral aspect of the humeral head; and 5.) Moderate to severe degenerative change of the acromioclavicular joint with associated marrow edema suggestive of an acute arthritic process. (PX1)

Petitioner was referred by Dreyer Medical Clinic to Dr Arif Saleem, an orthopaedic surgeon with Castle Orthopedic. On May 3, 2012, Dr Saleem examined Petitioner and reviewed the MRI arthrogram findings. Dr Saleem prescribed and performed an AC joint injection and provided light duty work restrictions of no use of the left arm. The injection did not provide Petitioner with lasting relief and Dr Saleem prescribed left shoulder surgery. (PX2)

Dr Saleem performed left shoulder surgery on July 18, 2012. The procedures performed included: 1.) Left shoulder arthroscopic debridement of partial rotator cuff tear as well as anterior and posterior labrum; 2.) Left shoulder arthroscopic distal clavicular excision: and 3.) Left shoulder open tenodesis. During the surgery it was discovered that Petitioner had left shoulder AC arthritis, superior labral tear, partial thickness articular sided supraspinatus tear as well as superior subscapularis partial tear and degenerative anterior posterior labral tear. A 6.25 Arthrex biotenodesis screw was inserted at the time of the surgery and remains in place. (PX2)

Post surgery, Petitioner completed a course of physical therapy and work conditioning at ATI Physical Therapy. On January 17, 2013, Petitioner completed a functional capacity evaluation that tested him at the Heavy physical demand level (PX3). Dr Saleem examined Petitioner for the final time on January 31, 2013 and provided Petitioner with a release to return to full duty work effective February 4, 2013 (PX2). Petitioner testified that the ATI Physical Therapy bill (PX6) was submitted to the insurance company and remains unpaid as of the hearing date.

Petitioner was off work between July 18, 2012 and October 17, 2012. Respondent was able to accommodate Petitioner's light duty work restrictions between March 14, 2012 and July 17, 2012 and between October 18, 2012 and February 3, 2013. Petitioner returned to work in a full duty capacity February 4, 2013 and remains in a full duty position as of the date of the hearing.

Petitioner testified that he notices constant weakness in his left arm. He estimates that he lifts 25% to 33% of what he used to be able to lift with the left arm before the accident. He is afraid to lift heavy items with his left arm for fear of dropping the items. Petitioner has to use his right arm more at work now due to his left arm condition. Petitioner testified that he has hardware in his shoulder that he fears will cause a re-tear if he lifts too much or overuses the left arm. Petitioner testified that he gets sharp pain if he sleeps on his left side. At work, if there is a heavy item to lift then Petitioner will ask for assistance before lifting the object.

As of the hearing date, Petitioner works full duty as a Truck Driver-Dock Man. He is a member of Local Union 179 out of Joliet. Petitioner testified that per Union contract he is scheduled to work at a minimum a 10.5 hour day with a 30 minute mandatory lunch (PX8). His normal schedule is 6:00AM to 4:30PM, Monday through Friday. As a Truck Driver, Petitioner is provided with a load and is expected to deliver the load before returning to the yard. All drivers are eligible to be sent on an additional run if they are in the yard before their 10.5 hour shift is completed (the "Tenth Hour"). In Petitioner's case, if he is in the yard before 4:30PM then he is eligible to be sent on another run and he is not allowed to refuse the work. If he is asked to perform a run after 4:30PM then he can refuse to perform the work. Petitioner testified that he always refuses the voluntary overtime. Petitioner testified that the last time he volunteered for any overtime was 15 to 20 years ago. In the 52 weeks before his accident he did not perform any overtime that was not considered mandatory.

Ms. Deborah McCoy testified on behalf of Respondent. Ms. McCoy testified she worked as an operations manager and was a direct supervisor of Petitioner. Ms. McCoy testified Petitioner never complained about being unable to do something at work or being in pain while at work since his return. She testified she would be the appropriate manager at ABF that Petitioner would contact about any complaints he may have.

Ms. McCoy also testified to Respondent's overtime policies. Ms. McCoy testified ABF overtime policies are dictated by the Union contract. She provided that the drivers have to work at least ten (10) hours a day, "if we need them to if business dictates if we're busy." She provided that their "runs" are based upon when they start their shifts. Ms. McCoy indicated that if someone is coming in on their eight hour, Respondent tries to assign a job that's going to take about two hours to complete. Ms. McCoy also testified that there are times when a driver will be required to stay out past their 10th hour and can't refuse.

At Respondent's request, Petitioner underwent a Section 12 examination with Dr. Ram Aribindi on May 31, 2013. Dr. Aribindi also performed an AMA permanent partial impairment rating. Dr. Aribindi was deposed on August 9, 2013. Dr. Aribindi testified Petitioner had full range of motion and a normal physical examination. Dr. Aribindi testified Petitioner was at MMI at the time he saw him, he was capable of returning to work full duty and he did not need any more treatment for his left shoulder. (RX 1)

Dr. Aribindi testified to his history of performing impairment ratings and explained the process of how an impairment rating is generated. Dr. Aribindi explained how according to the physical examination and subjective complaints of Petitioner, he was placed in a class according to the AMA Guidelines 6th Edition and applied different modifiers according to his clinical history. Dr. Aribindi provided an impairment rating of 3% of the upper extremity and 2% of the person as a whole. (RX 1)

With respect to (G.) What were Petitioner's earnings, the Arbitrator finds as follows:

Petitioner and Respondent did not agree on Petitioner's earnings during the year preceding the injury and did not agree on the average weekly wage ("AWW"). Petitioner claims his earnings in the year preceding the injury were $76,952.59 and the AWW calculated pursuant to Section 10 of the Act is $1,339.48. Respondent claims Petitioner's AWW calculated pursuant to Section 10 is $1,289.23.

In Petitioner's Exhibit 4, Petitioner presented wage information for the year preceding his injury. In calculating the AWW under Section 10, the Arbitrator used the check stubs starting on PX4, p. 3 and ending on PX4, p. 54. These checks cover the period between February 19, 2011 and February 18, 2012. This is the best evidence to use to calculate the AWW. The checks reflect the following:

1. The total gross earnings for this period are $76,952.59. All overtime is considered in this amount, paid at a rate of "time and a half".
2. Petitioner earned an hourly wage of $25.33 for the period between February 19, 2011 and March 26, 2011.
3. Petitioner earned an hourly wage of $25.73 for the period between March 27, 2011 and February 18, 2012.
4. Petitioner worked overtime in 47 of the 52 weeks in the year preceding his accident. The only weeks Petitioner did not work overtime were the weeks he took vacation.
5. For the weeks Petitioner took vacation, Petitioner was paid for 50 hours per week at his normal hourly rate of pay.
6. Petitioner averaged 12.02 overtime hours per week in weeks the 47 weeks he worked overtime.
7. The lowest amount of overtime worked by Petitioner in a week was 7.12 hours.
8. The highest amount of overtime worked by Petitioner in a week was 17.36 hours.

Petitioner testified that he is a member of Local Union 179 out of Joliet. Petitioner testified that per Union contract he is scheduled to work at least a 10.5 hour day. Petitioner has to take a 30 minute mandatory lunch every day (PX8). His normal schedule is 6:00AM to 4:30PM, Monday through Friday. As a Truck Driver-Dock Man, Petitioner is provided with a load and expected to deliver the load before returning to the yard. All drivers are eligible to be sent on a run if they are in the yard before their "Tenth Hour". In Petitioner's case, if he is in the yard before 4:30PM then he is eligible to be sent on another run and he is not allowed to refuse the work. If he is asked to perform a run after 4:30PM then he can refuse to perform the work. Petitioner testified that the last time he volunteered for any overtime was 15 to 20 years ago. In the 52 weeks before his accident he did not perform any overtime that was not considered mandatory.

Respondent's witness, Deborah McCoy, confirmed Petitioner's testimony in all respects. She confirmed that Petitioner did not volunteer for overtime in the year preceding his accident. She confirmed that any overtime on Petitioner's pay check stubs would have been the result of being sent on additional runs before his "tenth hour" was completed, and returning to the terminal after his "tenth hour".

The Arbitrator has reviewed all of the testimony and evidence regarding Petitioner's earnings and finds that based on the relevant case law, all of Petitioner's overtime hours should be included in the AWW calculation under Section 10 of the Act. All of the overtime hours were mandatory. Petitioner was scheduled and required to complete these hours. The Arbitrator finds that all overtime hours should be included at the standard hourly rate of pay for the period the overtime hours were worked (i.e., not at "time and a half"). Therefore, the AWW is calculated at $1,339.48. The calculations are as follows:

Period Ending	Rate of Pay	Regular Hours.	Overtime	Vacation	Holiday	Sick	Gross	OT at Flat Rate
2/26/2011	$25.33	40	10.14				$ 1,401.02	$ 1,270.05
3/5/2011	$25.33	40	11.18				$ 1,440.56	$ 1,296.39
3/12/2011	$25.33	40	10.86				$ 1,425.83	$ 1,288.28
3/19/2011	$25.33	40	10.36				$ 1,406.83	$ 1,275.62
3/26/2011	$25.33	40	7.12				$ 1,285.94	$ 1,193.55
4/2/2011	$25.73	40	9.61				$ 1,382.82	$ 1,276.47
4/9/2011	$25.73	40	9.91				$ 1,411.69	$ 1,284.18
4/16/2011	$25.73	40	10.3				$ 1,426.73	$ 1,294.22
4/23/2011	$25.73	40	10.05				$ 1,417.09	$ 1,287.79
4/30/2011	$25.73			50			$ 1,286.50	$ 1,286.50
5/7/2011	$25.73	40	8.08				$ 1,341.05	$ 1,237.10
5/14/2011	$25.73	40	11.81				$ 1,487.62	$ 1,333.07
5/21/2011	$25.73	40	12.68				$ 1,518.59	$ 1,355.46
5/28/2011	$25.73	40	12.5				$ 1,511.64	$ 1,350.83
6/4/2011	$25.73	32	9.94			8	$ 1,415.60	$ 1,284.96
6/11/2011	$25.73	40	13.59				$ 1,553.71	$ 1,378.87
6/18/2011	$25.73	40	14.11				$ 1,579.28	$ 1,392.25
6/25/2011	$25.73	40	14.24				$ 1,581.37	$ 1,395.60
7/2/2011	$25.73	40	15.66				$ 1,633.59	$ 1,432.13
7/9/2011	$25.73	32	13.73			8	$ 1,559.11	$ 1,382.47
7/16/2011	$25.73	40	15.61				$ 1,631.65	$ 1,430.85
7/23/2011	$25.73	40	16.14				$ 1,654.93	$ 1,444.48
7/30/2011	$25.73			50			$ 1,286.50	$ 1,286.50
8/6/2011	$25.73	40	17.36				$ 1,699.19	$ 1,475.87
8/13/2011	$25.73	32	11.29				8 $ 1,464.94	$ 1,319.69
8/20/2011	$25.73	40	16.08				$ 1,653.01	$ 1,442.94
8/27/2011	$25.73	40	14.22				$ 1,583.43	$ 1,395.08
9/3/2011	$25.73	40	12.79				$ 1,522.84	$ 1,358.29
9/10/2011	$25.73	32	10.3			8	$ 1,426.73	$ 1,294.22
9/17/2011	$25.73	40	14.61				$ 1,593.07	$ 1,405.12
9/24/2011	$25.73	40	11.78				$ 1,486.48	$ 1,332.30
10/1/2011	$25.73	32	12.85				8 $ 1,527.99	$ 1,359.83
10/8/2011	$25.73	40	14.02				$ 1,572.89	$ 1,389.93
10/15/2011	$25.73	40	13.52				$ 1,553.59	$ 1,377.07
10/22/2011	$25.73	40	11.62				$ 1,477.68	$ 1,328.18
10/29/2011	$25.73			50			$ 1,286.50	$ 1,286.50
11/5/2011	$25.73	32	11.94				8 $ 1,490.04	$ 1,336.42
11/12/2011	$25.73	40	14.72				$ 1,600.14	$ 1,407.95
11/19/2011	$25.73	40	11.27				$ 1,464.17	$ 1,319.18
11/26/2011	$25.73			50	16		$ 1,698.18	$ 1,698.18
12/3/2011	$25.73	24	8.69				$ 955.59	$ 841.11
12/10/2011	$25.73	40	11.46				$ 1,471.50	$ 1,324.07
12/17/2011	$25.73	40	11.55				$ 1,474.98	$ 1,326.38
12/24/2011	$25.73	32	11.57			8	8 $ 1,684.40	$ 1,532.74
12/31/2011	$25.73			50	8		$ 1,491.34	$ 1,492.34
1/7/2012	$25.73	32	9.51	8			$ 1,396.23	$ 1,273.89
1/14/2012	$25.73	32	10.64	8			$ 1,439.86	$ 1,302.97
1/21/2012	$25.73	40	12.31				$ 1,506.96	$ 1,345.94
1/28/2012	$25.73	40	8.85				$ 1,373.39	$ 1,256.91
2/4/2012	$25.73	32	10.89	8			$ 1,449.49	$ 1,309.40
2/11/2012	$25.73	40	12.24				$ 1,504.55	$ 1,344.14
2/18/2012	$25.73	40	11.26				$ 1,463.78	$ 1,318.92
		1,784.00	564.96	274.00	56.00	32.00	$ 76,952.59	$ 69,653.14
							$ 1,479.86	$ 1,339.48

With respect to (J.) Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical expenses, the Arbitrator finds as follows:

Petitioner presented medical bills from ATI Physical Therapy that were outstanding as of the date of the hearing (PX3 and PX6). The evidence shows that Petitioner received treatment at ATI between November 28, 2012 and January 17, 2013. Bills in the amount of $3,938.60 for the dates of service between January 7, 2013 and January 11, 2013, remain outstanding. The evidence shows that these bills were submitted to Respondent on February 8, 2013 and August 7, 2013 (PX5). The Arbitrator finds the treatment Petitioner received at ATI Physical Therapy was reasonable, necessary and causally related to the work accident. Specifically, this treatment was for the work conditioning completed in advance of the functional capacity evaluation. The bills are awarded pursuant to the Medical Fee Schedule in the amount of $1,490.50.

With respect to (K.) Underpayment of TTD and TPD benefits, the Arbitrator finds as follows;

TTD benefits of $892.99/week were awarded for 13 and 1/7 weeks, commencing July 18, 2012 through October 17, 2012, as provided in Section 8(b) of the Act. Respondent is entitled to a credit of $11,296.15 for temporary total disability benefits paid before the date of the hearing. The total amount awarded in TTD benefits, based on the AWW findings in Section "G" above, is $11,736.43. Therefore there is a TTD underpayment of $440.28.

Petitioner is awarded TPD benefits for 33 and 1/7 weeks, for the periods between March 14, 2012 and July 17, 2012 and October 18, 2012 through February 3, 2013, as provided in Section 8(a) of the Act. Based on the AWW findings in Section "G" above, the total TPD payable is $17,307.41. Respondent is entitled to a credit of $15,694.93 for TPD benefits paid before the date of the hearing. Therefore there is a TPD underpayment of $1,612.48. The calculations are below.

TPD Calculations

Period Ending	Rate	Reg. Hrs.	Overtime	Vacation	Holiday	Sick	Gross Earnings	TPD Due
3/17/2012	$9.69	40	3.18				$817.28	$ 348.13
3/24/2012	$9.69	40					$387.40	$ 634.72
3/31/2012	$9.69	32				8	$484.88	$ 569.73
4/7/2012	$10.07	40					$402.70	$ 624.52
4/14/2012	$10.07	40					$402.70	$ 624.52
4/21/2012	$10.07	40					$402.70	$ 624.52
4/28/2012	$10.07			50			$1,286.50	$ 35.32
5/5/2012	$10.07	40					$402.70	$ 624.52
5/12/2012	$10.07	40					$402.70	$ 624.52
5/19/2012	$10.07	40					$402.70	$ 624.52
5/26/2012	$10.07	40					$402.70	$ 624.52
6/2/2012	$10.07	32			8		$528.00	$ 540.99
6/9/2012	$10.07			50			$1,286.50	$ 35.32
6/16/2012	$10.07	40					$402.70	$ 624.52
6/23/2012	$10.07	40					$402.70	$ 624.52
6/30/2012	$10.07	40					$402.70	$ 624.52
7/7/2012	$10.07	24			8	8	$622.42	$ 478.04
7/14/2012	$10.07	32				8	$500.16	$ 559.55
7/21/2012	$26.18	8				8	$161.08	$ 147.75
10/20/2012	$10.07	16					$161.08	$ 147.75
10/27/2012	$10.07	40					$402.70	$ 624.52
11/3/2012	$10.07	40					$402.70	$ 624.52
11/10/2012	$10.07	40					$402.70	$ 624.52
11/17/2012	$10.07	40					$402.70	$ 624.52
11/24/2012	$10.07			30	16		$932.98	$ 271.00

12/1/2012	$10.07	24		20			$756.22	$	388.84
12/8/2012	$10.07	40					$420.70	$	612.52
12/15/2012	$10.07	32				8	$500.18	$	559.53
12/22/2012	$10.07	40					$420.70	$	612.52
12/29/2012	$10.07			30	16		$932.98	$	271.00
1/5/2013	$10.07	16		20	8		$756.22	$	388.84
1/12/2012	$10.07	32			8		$402.70	$	624.52
1/19/2013	$10.07	32					$322.16	$	678.21
1/26/2013	$10.07			50			$1,286.50	$	35.32
2/2/2013	$10.07	32			8		$402.70	$	624.52
TOTAL		1,032.00	3.18	250.00	72.00	40.00	$19,007.14		$17,307.41
							TOTAL TPD PAID		$15,694.93
							TOTAL TPD DUE		$1,612.48

With respect to (L.) What is the nature and extent of Petitioner's injury, the Arbitrator finds as follows:

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 regards to paragraph (i) of Section 8.1(b) of the Act:

i. Dr Ram Aribindi's AMA report and deposition were admitted into evidence (RX1). Dr Aribindi concluded that Petitioner's impairment is 3% of the left upper extremity or 2% whole person impairment. Dr Aribindi testified that he used the *Guides to the Evaluation of Permanent Impairment, Sixth Edition*, in reaching his conclusions ("*Guides*") Dr Aribindi used a Diagnosis Based Impairment to determine the Impairment Class and Impairment Range in his calculations. On page 387 of the *Guides*, on the bottom of the right hand column, it indicates that "If a patient has two significant diagnoses; for example rotator cuff tear and biceps tendinitis, the examiner should use the diagnosis with the highest causally related impairment rating for the impairment calculation." In reaching a Diagnosis Based Impairment, Dr Aribindi used Table 15-5, Shoulder Regional Grid, pages 401-405 of the *Guides*. Dr Aribindi testified that in his opinion he could have used AC joint arthritis (pg. 403), AC joint tendinitis (pg. 402) or biceps tendon dislocation-subluxation (pg. 404), and the results would have been the same (RX1, pg. 40-46 of deposition). This is true but Dr Aribindi should have used acromioclavicular (AC) joint injury or disease as the diagnosis (pg. 403). Since the Petitioner is status post distal clavicle resection (PX2), he would still have been considered a Class 1, but the range would have increased to between 8% and 12%. Obviously, this is a higher range

than that provided under AC joint arthritis (pg. 403), AC joint tendinitis (pg. 402) or biceps tendon dislocation-subluxation (pg. 404). Dr Aribindi should have used acromioclavicular (AC) joint injury or disease as the diagnosis (pg. 403) because it yields the highest impairment rating. Using Dr Aribindi's findings for Functional History, Physical Examination and Clinical Studies, the PPI rating is 10% of the upper extremity, or 6% whole person impairment.

With regards to paragraph (ii) of Section 8.1(b) of the Act:

ii. Petitioner continues to be employed in his pre-injury employment as a Truck Driver-Dock Man with Respondent. The Arbitrator takes judicial notice that this position is heavy work and concludes the Petitioner's PPD will be larger than an individual who performs lighter work.

With regards to paragraph (iii) of Section 8.1(b) of the Act:

iii. Petitioner is 61-years old. The Arbitrator considers the Petitioner to be an older individual and is less likely to live and work longer than an individual with the same injuries. Thus Petitioner's PPD is not as extensive than that of a younger individual.

With regards to paragraph (iv) of Section 8.1(b) of the Act:

iv. At the present time, there is no evidence that Petitioner's future earning capacity has diminished as a result of this injury. Petitioner continues to work with Respondent driving a truck and working the docks. Petitioner has remained in a full duty capacity with Respondent.

With regards to paragraph (v) of Section 8.1(b) of the Act:

v. Evidence of disability in Petitioner's treating medical records finds Dr Saleem performed left shoulder surgery on July 18, 2012. The procedures performed included: 1.) Left shoulder arthroscopic debridement of partial rotator cuff tear as well as anterior and posterior labrum; 2.) Left shoulder arthroscopic distal clavicular excision; and 3.) Left shoulder open tenodesis. During the surgery it was discovered that Petitioner had left shoulder AC arthritis, superior labral tear, partial thickness articular sided supraspinatus tear as well as superior subscapularis partial tear and degenerative anterior posterior labral tear. A 6.25 Arthrex biotenodesis screw was inserted at the time of the surgery and remains in place as of the date of the hearing.

Post surgery, Petitioner completed a course of physical therapy and work conditioning at ATI Physical Therapy. On January 17, 2013, Petitioner completed a functional capacity evaluation that tested him at the Heavy physical demand level. Dr Saleem examined Petitioner for the final time on January 31, 2013 and provided Petitioner with a release to return to full duty work effective February 4, 2013.

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 applying Section 8.1b of the Act, 820 ILCS 305/8.1b and considering the relevance and weight of all these factors, including Dr Aribindi's AMA impairment rating, the Arbitrator concludes that Petitioner has sustained a 15% loss of use to the person as a whole, or 75 weeks of PPD benefits.

With respect to (M.) Should penalties or fees be imposed upon Respondent, the Arbitrator finds as follows:

After reviewing the testimony and the evidence submitted by the parties, the Arbitrator finds Petitioner is entitled to attorney's fees under Section 16 in the amount of $1,662.40 and penalties under Sections 19(k) and 19(l) in the amounts of $2,770.68 and $10,000.00 respectively.

In reaching said Decision, the Arbitrator finds that Respondent failed to pay the outstanding medical bills of ATI Physical Therapy. Respondent failed to provide a legitimate defense as to why the bills were not paid. In addition, Respondent's conduct with its underpayment of TTD and TPD was unreasonable and vexatious.

Petitioner presented the outstanding ATI Physical Therapy bill to Respondent on February 8, 2013 and August 7, 2013. Respondent confirmed receipt of the medical bill (PX5). The evidence shows that the bills were related to Petitioner's work conditioning after his surgery (PX3). There is no dispute that the treatment was related to Petitioner's work accident.

Respondent claimed at the time of the hearing that the medical bills had been paid (AX1). A review of the records clearly shows that payments were never made for the dates of service between January 7, 2013 and January 11, 2013 (PX6 and RX8). Respondent's Exhibit 8 clearly shows that payment was never made for these dates of service. Per the Medical Fee Schedule, the outstanding medical bills should have been paid in the amount of $1,490.50.

The records show that Respondent paid TTD benefits between July 18, 2012 and October 17, 2012, at a weekly rate of $707.42, based on an AWW of $1,061.13. The evidence shows that Respondent recalculated the AWW on the eve of hearing and issued a TTD underpayment check that assumed an AWW of $1,289.23 (RX4). Based on the Arbitrator's findings in Section "G", there is still a TTD underpayment in the amount of $440.28. In Respondent's Exhibit 2, "Response to Petitioner's Petition for Section 8(a)/19(k)/19(l) Penalties and Section 16 Fees", Respondent claims Petitioner was paid TTD benefits pursuant to an AWW commensurate with the amount he made in a 40 hour work week. Respondent was put on notice by Petitioner of the underpayment no later than August 7, 2013 (PX5). However, Respondent was also aware of the Union contract requiring Petitioner to be eligible for a minimum of 50 hours per week (PX8). Respondent's own witness, Deborah McCoy testified that she is familiar with the Union contract requiring 50 hours per week and is also familiar with Petitioner's overtime all being mandatory. Respondent has no defense for not basing the AWW and TTD payments on all of the hours worked by Petitioner.

TPD benefits were paid between March 14, 2012 and July 17, 2012 and between October 18, 2012 and February 3, 2013 (RX4). Respondent maintains that they issued TPD benefits based on a collective bargaining agreement with the Union. Respondent maintains they paid more in TPD benefits than they would have under the Act, without the Union contract. Specifically, Respondent maintains Petitioner was paid 85% of his salary while working in the Alternate Work Program (RX2). Petitioner received salary at a reduced rate while working light duty and received a supplemental TPD check while he was in the Alternate Work Program (PX4 and RX4). The amount paid by Respondent in TPD benefits was less than that required under the Act. Specifically, based on the findings in Section "G" and the evidence presented at the time of the hearing, Respondent has underpaid TPD benefits in the amount of $1,612.48. Respondent has no defense for the underpayment.

For the forgoing reasons, the Arbitrator finds Respondent liable for the following penalties and attorney's fees:

Section 19(k):

The Arbitrator found the non-payment of medical bills and the underpayment of TTD and TPD benefits to be unreasonable and vexatious. The evidence shows that Respondent recalculated the AWW on the eve of hearing and issued a TTD underpayment check that assumed an AWW of $1,289.23. Respondent should not be able to avoid penalties by issuing a check on the eve of hearing. The Arbitrator awards 50% of the unpaid medical bills, TTD and TPD benefits payable as of November 13, 2013 as penalties under Section 19(k). The total unpaid benefits as of November 13, 2013 were $5,541.36, leaving a penalty under Section 19(k) of $2,770.68.

Section 19(l):

Having found that the underpayment of TTD and TPD benefits from March 14, 2012 through February 3, 2013 were unreasonable and vexatious. The Arbitrator awards $30.00 a day for each day that TTD and TPD was underpaid. The period from March 14, 2012 through November 14, 2013 is 975 days. $30.00 per day x 975 days would be $29,250.00. However, the maximum allowed under Section 19(l) is $10,000.00. Therefore, the total amount awarded under Section 19(l) is $10,000.00

Section 16:

Having found the Respondent's actions towards Petitioner to be unreasonable and vexatious, the Arbitrator awards attorney's fees under Section 16 in the amount of penalties, or $1,662.40 [20% x ($5,541.36 unpaid amounts + 2,770.68 (19k)].

STATE OF ILLINOIS)
) SS.
COUNTY OF DUPAGE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

VICTORIA WEIDENBACHER,

Petitioner,

vs.

NO: 10 WC 27409

MERIT HOME HEALTHCARE,

15IWCC0029

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, temporary total disability (TTD), causal connection, and permanent partial disability (PPD), and being advised of the facts and applicable law, reverses the Decision of the Arbitrator.

The Commission has considered all of the testimony, exhibits, pleadings and arguments submitted by the parties. Based on the totality of the evidence, the Commission finds that Ms. Weidenbacher failed to prove an accident arising out of and in the course of her employment on April 21, 2010. Petitioner's claim for compensation is therefore denied.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission makes the following findings:

1. Petitioner filed an Application for Adjustment of Claim on July 19, 2010 alleging injury to her back, right leg, and person-as-a-whole while changing a catheter at work on April 21, 2010.

2. Ms. Weidenbacher has been employed by Merit Home Healthcare since August 10, 2009. She had back issues dating back to December 2009; however, she testified that her prior back problems did not lead to medical treatment or surgery. T.13.

3. Petitioner testified that she bent over to change a Foley catheter on April 21, 2010 when she experienced extreme pain in her back, right buttock and right leg. T.16. She testified that the patient was in her bed in a high position and it was just a routine catheter change that she frequently did throughout the day. She had not experienced similar pain before. T.19.

4. She testified to bending over between 5 and 6 times per visit and would see between 5 and 6 patients per day. *Id.* Petitioner saw one to two more patients before she called her doctor. T.20.

5. The medical records entered into evidence demonstrate that Petitioner has a prior history of medical treatment to her back. Petitioner was seen at Primary Care West on September 18, 2009 for right flank back pain that had been present for 1 to 2 months. RX.2.

6. Petitioner presented to Health Source Chiropractic and Progressive Rehab on March 12, 2010 for back pain radiating to the right leg and right buttock. The date of onset was listed as March 3, 2010 after she tripped over an office chair. She had frequent pain, which she rated as 10 out of 10. Her current pain was 2 out of 10. She described her pain as shooting and sharp. Getting out of bed, sitting, stooping and getting in and out of a car aggravated her condition. Resting relieved her symptoms. PX.1.

7. Petitioner was seen by Dr. Josephine Mante on March 15, 2010 for back pain radiating to the right buttock and right leg. She had pain and stiffness in the back and leg that had constantly been present for one week. RX.2.

8. Petitioner underwent an MRI at Fox Valley Imagining on March 24, 2010 due to her low back pain radiating to the right lower extremity. There was a right paracentral disc herniation at L4-L5 and a broad base protruding disc with spinal stenosis at L5-S1. PX.1.

9. Weidenbacher was seen by Dr. Mante on March 26, 2010 for a follow-up of a lumbar strain. She had mild lumbar vertebral tenderness with paraspinal muscle spasm. She was diagnosed with degenerative lumbar disc disease. Pain management was discussed with patient. RX.2. Petitioner testified that, during this visit, she complained of pain, stiffness, weakness in her back and pain in both legs the frequency of which was daily and had been present for 1 to 2 months. T.30.

15IWCC0029

10. Petitioner testified that she discussed the MRI results with Dr. Mante on March 26, 2010. Dr. Mante recommended a pain doctor and various medications. T.31. She had to cancel her pain management consultation due to her mother's death. T.33. She was subsequently off work from the end of March 2010 through April 19, 2010 due to her mother's passing. T.31.

11. Petitioner testified that on April 21, 2010 her symptoms went from mild to excruciating following the work incident. Petitioner testified that she was taken to the ER via ambulance as she was non-ambulatory and was flat in bed for two days. T.21. She was in excruciating pain and could not sit up. T.22.

12. Ms. Weidenbacher was seen by Dr. Mante on April 23, 2010. Dr. Mante's record indicated no apparent mechanism for the back injury, but it had been present for two days. It was also noted that no apparent traumatic injury was present. She had intractable back pain with recent progression of worsening symptoms after bending down and she had urinary retention. Petitioner had been unable to get out of bed for the last 2 days and her last bowel movement was April 19, 2010. PX.1.

13. According to the pain report from Dr. Ramesh Bathina from Provena Mercy Medical Center dated April 23, 2010, Petitioner reported her pain began after a fall from a chair in February 2010. She noticed a relatively acute onset of pain in the lower back especially on the right side with some radiation to the right lower extremity. Her pain worsened progressively. She was going to see him sooner, but had to cancel due to a death in the family. Her pain began to improve and then she had a significant increase in pain with severe right lower extremity radiation to her toes. RX.3.

14. According to Dr. Mante's report dated April 24, 2010, Petitioner's back pain was improving and she was to see a pain specialist but cancelled. She returned to work on Monday and felt a little bit sore after her first day of work. The following morning she complained of pain in the right leg but it was tolerable. She began work and developed a stabbing pain of 10/10. The diagnosis was intractable back pain with recent progression of worsening symptoms after bending down and urinary retention. PX.1.

15. Petitioner underwent an MRI of the lumbar spine on April 24, 2010 at Provena Mercy Medical Center. The impression was degenerative disc disease at L4-L5 and L5-S1, right parasagittal disc bulge at L4-L5 with moderate central canal stenosis, and mild to moderate bilateral L5 neural foraminal stenosis. PX.1.

16. According to Dr. Thomas McGivney's consultation report dated April 26 2010, Petitioner first injured her back in February when she bent over and fell. Her back was stiff and sore, and got better over time. She re-injured her back while placing a catheter in a patient. She had severe back pain as well as severe radiating pain down

the leg that became progressively worse. He noted that the MRI revealed a fairly significant right sided disk hernation at L4-L5 on the right. Further noted was that Petitioner wanted to undergo surgery as she had a trip to Jamaica planned. PX.1.

17. Dr. McGivney performed a decompressive hemilaminotomy and diskectomy at L4-L5 on the right on April 28, 2010. PX.1.

18. Petitioner was seen by Dr. McGivney on July 27, 2010 and was released from his care. Dr. McGivney noted that she was not working and was not planning on returning to work. She was going to find another line work. She was to follow-up as needed. RX.7. On August 4, 2010, Dr. McGivney noted that Petitioner called and stated that her attorney asked for a note regarding her restrictions. He provided a note returning her to work without any restrictions. RX.7. Then on August 9, 2010, Petitioner called and asked for a note stating she could not return to home health care work. RX.7.

19. Dr. McGivney testified on February 19, 2013. He did not review any of her prior medical records and did not see the older MRI except for when it was shown to him just prior to his deposition. PX.2. pg.7. He diagnosed Petitioner with a fairly significant large herniated disc at L4-L5.

20. As for causation, Dr. McGivney stated that he has to take the patient at her word. She said she bent over and her back got worse and she had more leg pain. He thought that putting in the catheter aggravated or produced symptoms so severe that required her to go to the hospital. PX.2. pg.8. He stated that bending over and twisting was a mechanism of injury of a herniated disc. PX.2. pg.9.

21. Dr. McGivney was provided the prior MRI at the deposition and stated that the accident did not cause her to have a herniated disc as she obviously had one from another cause. PX.2. pg.10. He could only assume she wasn't as symptomatic prior to the accident as she was after the accident. *Id.* He never had access to both MRI films to compare them to determine whether the incident pushed out more disc, which was possible. PX.2. pg.11. He had no way of know what position the patient or Petitioner was in when the incident occurred. PX.2. pg.13.

22. Dr. McGivney noted that Weidenbacher told him that she was not intending to go back as a nurse as she could no longer do that job. He did not agree and felt that all she could not do was the weight lifting. PX.2. pg.16

23. On cross-examination, Dr. McGivney stated that complaints of pain radiating down her leg, stiffness, constant pain, and daily pain would be consistent with a herniated disc. PX.2. pg.18.

24. Dr. McGivney further testified that he could not state with any reasonable degree of medical and surgical certainty that the structure of the disc was changed, in any way, from the alleged April 21, 2010 accident. PX.2. pg.18. He was not aware that she was placed in pain management prior to April 21, 2010 or that she cancelled pain management. PX.2. pg.19. He was not aware that the Petitioner reported that she was a little bit sore after working her first day back on April 19, 2010. This is not unusual given she had a herniated disc. PX.2. pg.20. He was not aware that she told the doctor on April 20, 2010 that she had pain in her right leg. *Id.* She could have already been experiencing a symptomatic herniated disc. PX.2. pg.22. He was also not aware that Petitioner had not had a bowel movement since April 19, 2010 as she was afraid to sit as it hurt too much. PX.2. pg.24.

25. Petitioner underwent a Section 12 examination with Dr. Julie Wehner on December 27, 2010. She stated the MRI after the alleged accident showed the same findings as the previous MRI. The same complaints of back pain and right leg pain were present prior to April 21, 2010. The initial MRI already established the need for care including medication and a pain clinic evaluation. The action of bending over to put in a catheter did not constitute a new injury. The subjective complaints and radiologic findings were all present prior to this date. Petitioner was at MMI and could return to work full-duty. RX.8.

26. Dr. Wehner was deposed February 22, 2013. She noted that Petitioner, in her history, noted she slipped and fell onto her rear on December 24, 2009. She also reported that she injured herself at work on March 10, 2010. Those accidents were not mentioned in the medical records.

27. Dr. Wehner noted that Petitioner reported she did not have a bowel movement for a few days. Dr. Wehner stated that when someone has a herniated disc, their back pain is increased with Valsalva maneuvers. RX.1. pg.13. Not having a bowel movement since April 19, 2010 was consistent with the herniated disc.

28. She reviewed the April 24, 2010 MRI and compared it to the March 2010 MRI. She noted there was no significant change between the two MRIs. There were no acute findings on the second MRI. It is not uncommon to experience back pain from bending given she already had a herniated disc. RX.1. pg.17. There was no causal relationship between the MRI findings of April 24, 2010 and her bending on April 21, 2010. *Id.* Her symptoms prior to the alleged accident were similar to those after the accident. RX.1. pg.18. There was nothing acute found during the surgery that was caused by the bending activity. *Id.* The surgery was not necessitated by the bending activity and was the result of a pre-existing condition. *Id.*

29. On cross-examination, Dr. Wehner stated that it was credible that she may have bent forward and hurt. RX.1. pg.27. However, it was not credible if she said her symptoms changed dramatically from that point on.

30. Petitioner testified that she currently has back pain every day though it is very tolerable and she can walk every day. She has lower back pain in the morning and evening and sometimes it goes into her right leg. She is able to stay relatively comfortable taking Mortin only. Occasionally she needs muscle relaxers or Norco. She has to be careful with movement and bending. T.24. She tries to avoid bending positions for any prolonged period of time as it aggravates her back. *Id.* She is currently under no medical care. T.25.

The Commission is not bound by the Arbitrator's findings, and may properly determine the credibility of witnesses, weigh their testimony and assess the weight to be given to the evidence. *R.A. Cullinan & Sons v. Industrial Comm'n*, 216 Ill. App. 3d 1048, 1054, 575 N.E.2d 1240, 159 Ill. Dec. 180 (1991). It is the province of the Commission to weigh the evidence and draw reasonable inferences therefrom. *Niles Police Department v. Industrial Comm'n*, 83 Ill. 2d 528, 533-34, 416 N.E.2d 243, 245, 48 Ill. Dec. 212 (1981). Interpretation of medical testimony is particularly within the province of the Commission. *A. O. Smith Corp. v. Industrial Comm'n*, 51 Ill. 2d 533, 536-37, 283 N.E.2d 875, 877 (1972).

In order for accidental injuries to be compensable under the Act, a Petitioner must show such injuries arose out of and in the course of his employment. *Eagle Discount Supermarket,* 82 Ill. 2d at 337-38, 412 N.E.2d at 496; *Nabisco Brands, Inc. v. Industrial Comm'n,* 266 Ill. App. 3d 1103, 1106, 641 N.E.2d 578, 581, 204 Ill. Dec. 354 (1994)."Arising out of" refers to the requisite causal connection between the employment and the injury. In other words, the injury must have had its origins in some risk incidental to the employment. See *Eagle Discount Supermarket,* 82 Ill. 2d at 338, 412 N.E.2d at 496; *William G. Ceas & Co.,* 261 Ill. App. 3d at 636, 633 N.E.2d at 998. "In the course of" refers to the time, place, and circumstances under which the accident occurred. See *William G. Ceas & Co.,* 261 Ill. App. 3d at 636, 633 N.E.2d at 998. Whether the claimant suffered from a compensable accident is a question of fact to be determined by the Commission. *National Freight Industries v. Illinois Workers' Compensation Comm'n,* 2013 IL App (5th) 120043WC, ¶ 26, 993 N.E.2d 473.

The evidence demonstrates that Ms. Weidenbacher had a significant pre-existing back condition that required medical treatment between September 2009 and March 26, 2010, less than one month prior to the alleged accident. Petitioner underwent an MRI in March 2010 which confirmed an L4-L5 disc herniation. She was then referred to pain management but had to cancel due to a death in the family. She was then off work for several weeks before returning to work on April 19, 2010. The medical records establish that she had pain after her first day back that worsened over night. The medical records further confirm that Petitioner was unable to have a bowel movement prior to the alleged accident due to pain. Both Dr. McGivney and Dr. Wehner noted this showed the presence and significance of her condition.

15IWCC0029

After having been admitted into the hospital on April 23, 2010, Petitioner underwent a second MRI that again showed the L4-L5 herniation. However, Dr. McGivney was not given the opportunity to review the MRI to compare it to March 24, 2010 MRI. Dr. McGivney testified that he was unaware of the prior MRI and never reviewed the prior medical records. It was not until his deposition that he learned of the prior MRI. He then testified that he could not state with any reasonable degree of medical certainty whether the incident caused any change in the already symptomatic condition. Dr. Wehner, on the other hand, reviewed both MRIs and noted that there was no change between the two MRIs. Based on Dr. McGivney's incomplete review of the records, the Commission finds Dr. Wehner's opinions more persuasive.

The evidence supports that Petitioner was already symptomatic on April 21, 2010 from her pre-existing herniated disc at L4-L5. The Commission finds no credible objective evidence establishing a change in Petitioner's condition following the alleged April 21, 2010 incident. The Commission therefore finds Petitioner failed to prove an accident arising out of and in the course of her employment on April 21, 2010.

IT IS THEREFORE ORDERED BY THE COMMISSION that that the Decision of the Arbitrator filed November 20, 2013, is hereby reversed as Petitioner failed to prove she sustained an accidental injury arising out of and in the course of her employment with Respondent on April 21, 2010, and, therefore, her claim for compensation is hereby denied.

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

DATED: JAN 1 5 2015

MJB/tdm
O: 11/18/14
052

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WEIDENBACHER, VICTORIA
Employee/Petitioner

Case# **10WC027409**

MERIT HOME HEALTHCARE
Employer/Respondent

15IWCC0029

On 11/20/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.10% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0226 GOLDSTEIN BENDER & ROMANOFF
DAVID FEUER
ONE N LASALLE ST SUITE 2600
CHICAGO, IL 60602

0507 RUSIN MACIOROWSKI & FRIEDMAN LTD
JOHN MACIOROWSKI
10 S RIVERSIDE PLZ SUITE 1530
CHICAGO, IL 60606-3833

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

Victoria Weidenbacher,
Employee/Petitioner

v.

Merit Home Healthcare,
Employer/Respondent

Case # **10** WC **27409**

Consolidated cases: **none**

15IWCC0029

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Peter M. O'Malley**, Arbitrator of the Commission, in the city of **Wheaton**, on **8/7/13**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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 _____

15IWCC0029

FINDINGS

On **4/21/10**, 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 not*** causally related to the accident.

In the year preceding the injury, Petitioner earned **$31,200.00**; the average weekly wage was **$600.00**.

On the date of accident, Petitioner was **51** years of age, ***single*** with **no** dependent children.

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

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

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

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

ORDER

The Arbitrator finds that while Petitioner sustained accidental injuries arising out of and in the course of her employment on April 21, 2010, she failed to prove that her current condition of ill-being with respect to her lower back is causally related to said accident. Accordingly, Petitioner's claim for compensation is hereby denied.

No benefits are awarded.

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

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

Signature of Arbitrator

11/19/13
Date

NOV 20 2013

STATEMENT OF FACTS:

Petitioner commenced employment with respondent on August 10, 2009 as a part-time home health care nurse. Petitioner would be paid $50.00 per home visit and see up to five to six individuals on any given day.

Petitioner's family physicians were Dr. Josephine Mante and Dr. David Mante at Primary Care West. Petitioner was seen at that facility on September 18, 2009 and gave a history of right flank pain of one to two months. (R. Ex. 1, Deposition Exhibit 2). She returned on October 13, 2009 with a history again of right flank pain. (R. Ex. 1, Deposition Exhibit 2).

Petitioner saw Josephine Mante on March 15, 2010 and acknowledged stating a history of back pain radiating to the right buttock and right leg. Petitioner complained of pain, stiffness, and back pain into the right leg of less than one week onset that was constant. She denied any trauma or strenuous lifting. (R. Ex. 1, Deposition Exhibit 2). Physical examination on that date revealed pain in the lumbar area and right hip, tenderness with stiffness to the right buttock to right thigh, and right lower leg pain with sharp shooting tingling. Under the occupational history petitioner denied her job involving any heavy lifting. (R. Ex. 1, Deposition Exhibit 2). Petitioner was diagnosed as having low back pain and sciatica. She was referred for lumbar spine x-ray and an MRI.

Petitioner underwent the x-ray at Fox Valley Imaging on March 17, 2010. The history was recorded of "Low back pain radiating to the right leg". (R. Ex. 1, Deposition Exhibit 2). The impression was degenerative disc disease at L5-S1 and mild spondylosis at L2-L3. Petitioner underwent the MRI of the lumbar spine at Fox Valley Imaging on March 24, 2010. The history was "Low back pain radiating to the right lower extremity". The MRI was interpreted as showing degeneration at L4-L5 and a moderate right paracentral focal protruding disc with extension into the right neural foramina causing severe right neuroforaminal stenosis. The impression was right paracentral disc herniation at L4-L5. (R. Ex. 1, Deposition Exhibit 2).

Following the MRI petitioner was seen by Dr. Josephine Mante on March 26, 2010. She presented with complaints of pain, stiffness, weakness, back pain, pain in both legs of one to two month duration on a daily basis. She again denied any trauma or lifting as a precipitating cause. (R. Ex. 1, Deposition Exhibit 2). Dr. Mante reviewed the MRI with petitioner and noted that it showed a disc herniation. She put petitioner on medications and discussed pain management and physical therapy. (R. Ex. 1, Deposition Exhibit 2).

No record was produced of petitioner undergoing physical therapy. Petitioner testified that she had an appointment scheduled with pain specialist Dr. Ramesh Bathina, but did not keep same due to the sickness of her mother. Petitioner indicated she did not work from the end of March 2010 until Monday, April 19, 2010, as her mother was ill and subsequently passed away.

Petitioner returned to work on Monday, April 19, 2010. She subsequently advised Dr. David Mante on April 23 that she felt a little bit sore after her first day of work. The following morning she had pain in her right leg. (R. Ex. 1, Deposition Exhibit 6). Petitioner admitted to some soreness on Monday, April 19, and having pain in her right leg on April 20.

Petitioner was admitted to Provena Mercy Medical Center on April 23, 2010. The history recorded was of chronic back pain, having an MRI in March, being unable to walk for the last several days and denying any recent trauma. (R. Ex. 1, Deposition Exhibit 4). On the physical exam it was also noted that no trauma or injury was present. (R. Ex. 1, Deposition Exhibit 4, p. 3). She was seen by the physical therapist on April 24

and gave a history of the prior MRI and stated the back pain originated in late February and recently progressed where she was unable to move. (R. Ex. 1, Deposition Exhibit 4, p. 6).

Petitioner saw pain physician Dr. Ramesh Bathina on April 23, 2010. Petitioner stated her pain started from a trivial fall from a chair in February with her noticing relatively acute onset of pain in the low back, especially on the right side, with some radiation to the right lower extremity. Noted was the fact that the intensity of her low back and right lower extremity pain was variable depending upon the position she was in. She stated she had been having a lot of problems sitting to such a point that she had sitting intolerance and was afraid to go to the toilet for a bowel movement. The doctor indicated petitioner was scheduled to see her, but the appointment was postponed due to a death in the family. It was noted because of the severity of her pain she was admitted to the hospital. (R. Ex. 1, p. 3).

Petitioner underwent a second lumbar MRI on April 24, 2010. No prior films were available for comparison. The MRI was interpreted as showing a right parasagittal disc bulge at L4-L5 with moderate central canal stenosis. (R. Ex. 1, p. 3).

Dr. McGivney saw petitioner in consultation initially on April 26, 2010.

Petitioner testified that on Wednesday, April 21, she was seeing a quad patient to change a Foley catheter. Petitioner specifically stated that there was nothing unusual about the activity as the bed was in high position, and it was a routine Foley catheter change. Petitioner testified that while bending she experienced excruciating pain in her right leg. She saw one patient thereafter.

Petitioner was subsequently taken by ambulance two days later to the emergency room.

Dr. McGivney gave his evidence deposition testimony on February 19, 2013. On direct examination he testified that as petitioner stated she had the onset of the symptomatology on April 21 a causal connection could exist. Dr. McGivney was not aware of the fact of the prior MRI of March 24, 2010, stating he had no record of the previous MRI in her chart and was not aware of the fact that she had a herniated disc previously diagnosed at that level until the pre-deposition conference of February 19, 2013. (P. Ex. 2, p. 9, 10). Dr. McGivney, once being aware of the prior MRI, stated that the activity of April 21 did not cause her to have a disc herniation because she obviously had one there from some other cause. (P. Ex. 2, p. 10). He indicated he did not have the ability to compare both MRIs side by side to see if the disc was pushed out more.

He testified that changing a Foley catheter is not heavy work. (P. Ex. 2, p. 12). Dr. McGivney indicated that bending over to tie one's shoes would put more pressure on an existent disc than the activity of bending for the Foley catheter. (P. Ex. 2, p. 13). Dr. McGivney acknowledged that he did not have any understanding as to how petitioner was positioned or the mechanism of the occurrence. (P. Ex. 2, p. 13).

Dr. McGivney indicated that he offered to treat petitioner conservatively, but petitioner acknowledged due to an upcoming wedding in Jamaica in two weeks she elected for surgical intervention. (P. Ex. 2, p. 14).

Dr. McGivney did not review any records of care preceding his consultation of April 26, 2010. (P. Ex. 2, p. 18). He acknowledged that complaints that petitioner previously voiced such as those on March 15 of pain radiating down her leg, stiffness, and constant daily pain would be consistent with the herniated disc that he found at the time of surgery. (P. Ex. 2, p. 18). He only saw the prior MRI report at the time of his evidence deposition and acknowledged it was at the same level he found at the time of surgery. (P. Ex. 2, p. 18). He could not state with any reasonable degree of medical and surgical certainty that the structure of the disc or spine was changed in any

way by what allegedly occurred on April 21, 2010, not having the MRI films for comparison purposes. (P. Ex. 2, p. 18). If he had the MRI films he would be in a better position to render such an opinion. (P. Ex. 2, p. 19).

He was not aware of the fact that petitioner had been recommended for a pain management program prior to April 21 but cancelled the appointment due to an illness and death in the family. (P. Ex. 2, p. 19). He was not aware of the fact that petitioner was off work from the end of March until April 19 and gave a history to Dr. Mante of being sore on that date with pain in her right leg on Tuesday, April 20. The doctor indicated that this would indicate petitioner was symptomatic compatible with a symptomatic herniated disc. (P. Ex. 2, p. 20, 21).

He admitted he had no understanding of the mechanism of events of April 21, and petitioner did not tell him that she was lifting or twisting at the time of the occurrence. (P. Ex. 2, p. 21). He stated the simple act of bending forward is an activity that is performed numerous times by every individual in everyday life. (P. Ex. 2, p. 21). He indicated it would be more stressful on a disc to tie one's shoes or to bend down to pick up a newspaper from a driveway or retrieve an object out of the trunk of an automobile. (P. Ex. 2, p. 21). He conceded that the act of bending on April 21 and petitioner having pain merely could have been a symptom of the already symptomatic herniated disc. (P. Ex. 2, p. 22). He could not state with any reasonable degree of medical and surgical certainty that the structure of the spine was changed in any way by what occurred on April 21, not having the benefit of reviewing both MRIs. (P. Ex. 2, p. 22).

Dr. McGivney indicated he released petitioner to regular duty work August 4 based upon his clinical exam without restriction. (P. Ex. 2, p. 24, 25). Petitioner called the office complaining about the note and requested a note be written not returning her to home healthcare, and without additional clinical exam he gave her a 50 pound restriction. (P. Ex. 2, p. 25).

Petitioner subsequently returned to work elsewhere. She testified to experiencing pain with bending and taking ibuprofen. All of the medical bills were paid by a group carrier. Respondent agreed to hold petitioner harmless from any claim by the group carrier for recoupment in the event of a finding of liability.

Petitioner was examined at respondent's request by Dr. Julie Wehner on December 27, 2010. (R. Ex. 1, Deposition Exhibit 8). Dr. Wehner is a board certified orthopedic surgeon. (R. Ex. 1, p. 4). Dr. Wehner in addition to evaluating petitioner reviewed all relevant medical records consisting of those from Primary Care, the MRI report of March 24, 2010 and films of that study, Dr. Bathina's report, the admission records from Provena St. Joseph, the MRI report of April 24, 2010 and the films of it, Dr. Mante's report of April 23 and records from Dr. McGivney.

Dr. Wehner found significant Dr. Mante's note of March 15, 2010 as petitioner was complaining of back pain and right sciatica which was consistent with the MRI of March 24, 2010 which showed a herniated disc.

Dr. Wehner reviewed the MRI report of March 24, 2010 and films and noted that they demonstrated a right L4-L5 herniated disc. (R. Ex. 1, p. 11). She noted that Dr. Mante diagnosed same in his note of March 26, 2010. She felt that petitioner's complaints of pain were compatible with a herniated disc.

Dr. Wehner also noted that petitioner indicated that she did not work due to the illness and death of her mother until the week of April 19. She also noted petitioner having problems sitting to the point where she was afraid to have a bowel movement. This was significant as it could increase symptomatology with Valsalva maneuvers. (R. Ex. 1, p. 13).

Dr. Wehner found significant the admission record of April 23 as petitioner stated her condition was chronic back pain and a denial of recent injury. (R. Ex. 1, p. 14).

Dr. Wehner reviewed the April 24, 2010 MRI and the actual film and compared it to the March 24, 2010 film, noting they were both the same with no acute change. (R. Ex. 1, p. 16). Dr. Wehner also noted that Dr. Mante took a history of petitioner returning to work on April 19, being sore, and on Tuesday having pain down her right leg. She indicated those complaints would be consistent with a symptomatic herniated disc. (R. Ex. 1, p. 16). She stated that the act of bending over would not be different than any everyday activity of life such as putting on your shoes, socks, or a pair of pants. The mechanism would not be different than the activity of daily living. She testified that given the fact petitioner already had a herniated disc based upon the March 24 MRI, it would not be unusual for her to experience pain while bending. (R. Ex. 1, p. 17).

Dr. Wehner testified based upon her examination, review of records and MRI films that there was no causal relationship between the MRI finding of April 24, 2010 and the activity of her bending over on April 21, 2010. (R. Ex. 1, p. 17). She based this upon the fact that the MRI finding was preexistent, and her symptoms were similar after that date. The operative report was further consistent with what was demonstrated on the MRI of March 24, 2010. (R. Ex. 1, p. 18). She testified that the operative report did not reveal any acute finding that would have been caused by the activity of bending on April 21, 2010. (R. Ex. 1, p. 18). It was her opinion within a reasonable degree of medical and surgical certainty that the surgery of April 26, 2010 was not necessitated in any way by the activity of bending on April 21. (R. Ex. 1, p. 18). She based this on the fact that the MRI finding was preexistent and petitioner was symptomatic. (R. Ex. 1, p. 19). The fact that petitioner may have experienced pain with bending was caused by the already symptomatic disc. (R. Ex. 1, p. 29). The fact that she was sore upon her return to work on Monday, April 19 and had pain down the leg on Tuesday, April 20 would all be symptoms present due to the fact that the herniated disc was symptomatic. (R. Ex. 1, p. 29).

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

Petitioner testified that on April 21, 2010 she was bending over a patient to change a catheter when she experienced excruciating pain in her lower back on the right side, in her right buttocks and down her right leg. She indicated that she saw one more patient and called her doctor.

Petitioner subsequently visited Provena Mercy Medical Center on April 23, 2010. A hand written record on that date notes a chief complaint of back pain as well as the fact that Petitioner had undergone an MRI one month earlier, revealing spurring and a bulging disc. This note also relates that Petitioner "[s]tates last 2 days unable to walk due to pain. No recent trauma." (PX1).

In a "History and Physical" April 24, 2010 the following history was recorded: "This is a 51-year-old female with a history of back pain. In late March symptoms were improving wit anti-inflammatory medications and muscle relaxants. An MRI was done as an outpatient, which showed paracentral disk herniation at L4-5 with broad-based protruding disk with spinal stenosis in L5-S1. She was clinically improving with conservative treatment, though she was recommended to see the pain specialist, but has not seen the physician as of yet at the present time. Vicki was improving with regards to her back pain to the point where she had returned to work earlier this week, Monday, and felt a little bit sore after the first day of her work. The following morning she complained of pain in the right leg but tolerable, and on bending at work she developed a stabbing pain of 10/10 in intensity, and she has had problems with just movement as well as bearing weight on her right leg. She had

called her physicians and was arranged for an appointment, though pain was so intense that she was unable to come to her clinic and subsequently was brought to the emergency room for further evaluation." (PX1).

In a "Consultation Report" dated April 26, 2010, Dr. McGivney recorded that Petitioner "... states she first injured her back in February when she bent over at her work in a little small area and fell. She states her back which was just stiff and sore and seemed to get better over time with some Naprosyn and a Medrol Pak. She states that she re-injured her back while placing a Foley in a patient. She works as a home health nurse. At that point, she had severe back pain as well as severe radiating pain down the leg that became progressively worse ..." (PX1).

Based on the above, and the record taken as a whole, including Petitioner's credible testimony as to the circumstances surrounding the incident, the Arbitrator finds that Petitioner sustained accidental injuries arising out of and in the course of her employment on April 21, 2010. Along these lines the Arbitrator notes that the evidence shows that an incident occurred at work on the date in question while Petitioner was bending to insert a Foley catheter in a patient.

The real question, however, is whether Petitioner's current condition of ill-being relative to her lower back is causally related to said incident.

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

Prior to the accident, Petitioner presented to her family physician on March 15, 2010 with a history of constant back pain radiating down the right buttock and right leg with pain, stiffness and an onset of less than one week. She was diagnosed as having back pain with sciatica, and an MRI was ordered. The MRI was performed on March 24, 2010 and revealed a herniated disc at L4-L5. Her doctor advised her of this during the visit of March 26, 2010. Petitioner was to see a pain physician but did not do so due to the death of her mother. Petitioner did not work from the end of March until April 19, 2010. When she returned to work she admitted to being sore and having pain down her right leg on April 20, 2010. When petitioner visited the emergency room two days after the accident in question, the record reveals the initial history of chronic back pain and a denial of recent injury. However, subsequent notes do reference an incident at work wherein she felt increased back pain while bending to insert a catheter in a patient (See issue "C", supra).

Treating orthopedic surgeon Dr. McGivney testified that he was not aware of the mechanism of injury or of the fact that a prior MRI even existed. He only saw the MRI report at the time of this deposition at which time he agreed that the herniated disc predated the accident on April 21, 2010. Not having the ability to compare the MRI films he could not state that the structure of the spine was changed in any way by the activity of bending on the date in question. Furthermore, Dr. McGivney conceded that Petitioner could have experienced was a symptom of the already symptomatic herniated disc. (PX2).

At the request of the Respondent, Petitioner was examined by Dr. Wehner. Dr. Wehner was able to compare the actual MRI films and noted that they did not differ in any significant way. She also testified that Petitioner was already symptomatic from the March 24, 2010 diagnosed herniated disc and that her complaints of not having a bowel movement since April 19, 2010 was a secondary effect of the herniated disc. Finally, Dr. Wehner opined that there was no causal relationship between the MRI findings of April 24, 2010 and the incident of bending on April 21, 2010 given that "[t]he findings on the MRI were similar to an MRI that preexisted that day, and her symptoms were also similar to the symptoms after that date, and the type of complaints that she was having would be compatible with the type of findings on the MRI that were see prior to that date." (RX1, pp.17-18).

Based on the above, and the record taken as a whole, the Arbitrator finds that Petitioner failed to prove by a preponderance of the evidence that her current condition of ill-being relative to her low back is causally related to the accident on April 21, 2010. More to the point, the Arbitrator finds that Petitioner's condition of ill-being – namely, a herniated disc at L4-L5 – clearly pre-existed the incident in question, as evidenced by the previous MRI results. Furthermore, the record shows that Petitioner continued to have ongoing complaints of low back pain, with radiation into her right leg, during the days leading up to the incident in question. Simply put, Petitioner suffered a temporary exacerbation of a pre-existing condition that was already well on its way and for which she was actively treating. And while there was no express recommendation for surgical intervention prior to the accident, there was a recommendation for the services of a pain management specialist pending. More importantly, the medical evidence, including the testimony of both Dr. McGivney and Dr. Wehner, strongly suggests that the possibility of surgery was by no means contraindicated prior to the accident in question. In fact, after exhausting conservative treatment, surgery would have been the natural and eventual course of action. Indeed, the only reason further conservative methods were not instituted, even after the accident, was Petitioner's desire to have the surgery in lieu of such measures in anticipation of a planned vacation.

Therefore, the Arbitrator finds that the incident on April 21, 2010 had no appreciable impact on Petitioner's underlying condition, and as such her claim for compensation is hereby denied.

WITH RESPECT TO ISSUE (J), WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY AND HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES, THE ARBITRATOR FINDS AS FOLLOWS:

Based on the above, and the record taken as a whole, and in light of the Arbitrator's determination as to causation (issue "F", supra), the Arbitrator finds that Petitioner failed to prove her entitlement to medical expenses pursuant to §8(a) of the Act. Accordingly, Petitioner's claim for same is hereby denied.

WITH RESPECT TO ISSUE (K), WHAT AMOUNT OF COMPENSATION IS DUE FOR TEMPORARY TOTAL DISABILITY, THE ARBITRATOR FINDS AS FOLLOWS:

Based on the above, and the record taken as a whole, and in light of the Arbitrator's determination as to causation (issue "F", supra), the Arbitrator finds that Petitioner failed to prove her entitlement to temporary total disability benefits pursuant to §8(b) of the Act. Accordingly, Petitioner's claim for same is hereby denied.

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

Based on the above, and the record taken as a whole, and in light of the Arbitrator's determination as to causation (issue "F", supra), the Arbitrator finds that Petitioner failed to prove her entitlement to permanent partial disability benefits. Accordingly, Petitioner's claim for same is hereby denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF LASALLE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jose Ruben Meraz,

Petitioner,

vs.

NO: 11 WC 36355

15IWCC0030

Minute Men Staffing,

Respondent.

DECISION AND OPINION ON REVIEW

Respondent appeals the Decision of Arbitrator Granada in a §19(b) proceeding finding that as a result of accidental injuries arising out of and in the course of his employment on July 22, 2011, Petitioner was temporarily totally disabled from July 23, 2011 through August 11, 2011 and from October 5, 2012 through February 28, 2014, the date of arbitration, a period of 76 weeks, that he is entitled to $921.00 in medical expenses, that he is entitled to prospective medical care and ordered Respondent to authorize treatment proposed by Dr. Domb, including left hip surgery. The issues on Review are whether a causal relationship exists between those injuries and Petitioner's current condition of ill-being and if so, the extent of temporary total disability, the amount of medical expenses and whether he is entitled to prospective medical care. The Commission, after reviewing the entire record, reverses the Decision of the Arbitrator finding that Petitioner failed to prove that a causal relationship exists between those injuries sustained on July 22, 2011 and his current condition of ill-being and denies Petitioner's claim for the reasons set forth below.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission finds:

1. The Arbitrator noted that Petitioner had two claims pending before the IWCC. This case only deals with a left hip injury claim (Tr 9).

2. Petitioner, a 55 year old laborer, testified through an interpreter. He was working for Respondent on July 22, 2011. On that date, Petitioner and others were going to lift a trailer on top of another trailer and there were 2 stones. It was very high and they were trying to raise the platform. There was a lot of pressure from the supervisors to complete the work faster. Petitioner was approached by a coworker who asked to help him move the platform. Petitioner asked him to do it with a forklift, but since he was in a rush, he did not agree to that. They tried to lift the platform and it gave up on them and it fell on Petitioner (Tr 13). The platform was a very long piece of metal that was used to hold cement walls, the ones that are used to make buildings (Tr 14). The piece of metal fell on Petitioner's head, elbows, left leg and feet (Tr 14). He did not know how much the piece of metal weighed, but between 3 of them, they could not lift it (Tr 14). As soon as the piece of metal was lifted off him, Petitioner noticed his left hip and left leg had a burning sensation, like he was in an oven burning in flames (Tr 14-15). His left leg had a bag of blood that looked like a hematoma and it was very black (Tr 15). From that point on, Petitioner stopped having the same strength in his legs, particularly the left leg (Tr 15). He does not have the same strength that he used to (Tr 15).

Petitioner was taken to the company doctor at Tyler Clinic and was treated July 22, 2011 (Tr 15). He continued to treat at Tyler Clinic in July 2011 and into August 2011. He was having a lot of left leg pain, especially in his left hip (Tr 16). The doctors at Tyler Clinic drained that area of his left leg (Tr 16). In August 2011, Petitioner went back to work on a light duty basis at Respondent (Tr 17). He attended prescribed physical therapy. The doctors at Tyler Clinic did not send him to a different doctor (Tr 17). Petitioner saw Dr. Suchy at Tyler Clinic on August 11, 2011 and he treated the hematoma (Tr 18). Petitioner returned to work at the same location where the injury happened, a cement company (Tr 18). When he returned to work in August 2011, Petitioner noticed he was not the same person, he did not have enough strength, especially with his left leg, and the pain never went away (Tr 18). The pain was on the left side of his body from his hips down all the way to the legs (Tr 19). It would sound true if the records show that Dr, Suchy or the doctors at Concentra (Tyler) released him from their care on September 21, 2011 (Tr 19). Petitioner testified that from the time of the accident until the present, he is a different person, he never stopped feeling pain and the pain never goes away, especially in his left leg (Tr 19). He asked the doctors to send him back to work because he was in a very difficult situation where he was about to lose his house and if he did not show any proof of income, he would have lost his house (Tr 20).

In October 2011, Petitioner's employment with Respondent was terminated (Tr 20). He went to a temporary agency and got a job at Caterpillar, which he worked at for the next 8 or 9 months (Tr 21). He had no new injuries while working there and continued to have pain (Tr 21). Petitioner returned to Concentra (Tyler) on March 1, 2012 because he was feeling very bad from his left hip and it felt like his left leg was lacking strength, which he still feels (Tr 22). He

treated at Concentra (Tyler) a few more times in March 2012 and was then released. At that time his left hip was feeling bad (Tr 22).

Because his pain was not going away, Petitioner saw Dr. Durkin at Hinsdale Orthopaedics (Tr 23). He reported what happened to Dr. Durkin (Tr 23). Dr. Durkin recommended diagnostic studies, which he underwent (Tr 23). Dr. Durkin then referred Petitioner to Dr. Domb, one of his partners. Petitioner saw Dr. Domb on July 2, 2012 and at that time, his left hip was very bad and he had very sharp pain in his left leg and no strength (Tr 24). He told Dr. Domb about his July 22, 2011 injury (Tr 25). If Dr. Domb's records note an injury in October 2011, there was confusion with the doctor as his injury was not in October 2011, but in July 2011 (Tr 25). Petitioner testified he did not injure his hip in October 2011 (Tr 25). He discussed treatment options with Dr. Domb, which included surgery and physical therapy (Tr 25). Petitioner followed up with Dr. Domb's assistant on October 5, 2012 (Tr 26). At that time his left hip was doing very bad (Tr 26). As the days passed, Petitioner felt his left leg get number. If he went to the bathroom or sat for 5 minutes, his left leg would get numb and cramped (Tr 26). As he was testifying, his left leg was numb and he could not feel it (Tr 26). On October 12, 2012, Petitioner discussed surgery and physical therapy with Dr. Domb's assistant. That day, he was placed on sedentary restriction (Tr 26). He was prescribed physical therapy, which he attended at ATI. He had no improvement with physical therapy (Tr 27).

About a year later, Petitioner followed up with Dr. Domb on October 24, 2013 (Tr 27). At that time, his left hip was completely bad (Tr 27). Dr. Domb still recommended left hip surgery and that he not work (Tr 28). Petitioner has not been able to work since October 5, 2012, when Dr. Domb's office placed him on restricted duty (Tr 28). He did not remember if he had seen Dr. Domb since October 2013 (Tr 28). Petitioner currently noticed that his left hip felt very bad and his left leg is cramping and numb (Tr 28). On October 24, 2013, Dr. Domb recommended physical therapy, which Petitioner attended and it recently ended (Tr 28-29). He received physical therapy for his left hip and back (Tr 29). He has not had any new injuries to his left hip since July 22, 2011(Tr 29). He has never had any injuries to his right hip (Tr 29). He had never injured his left hip before July 22, 2011 (Tr 29). At Respondent's request, Petitioner saw Dr. Stover in January 2013 (Tr 29). Petitioner wanted to undergo the surgery recommended by Dr. Domb and believed his left hip will be better with surgery (Tr 30).

On cross-examination, Petitioner testified that on July 22, 2011, after the accident he went to Tyler Medical Services (Tr 30). A number of x-rays were taken on that date (Tr 30). The x-ray results were not explained to him, but he was told he was okay (Tr 30). The x-rays showed he did not have any fractures (Tr 30). Petitioner testified he told the doctors at Tyler Medical Services that a metal object struck him along the thighs and rolled down striking his left knee (Tr 31). He told the doctor at Tyler Medical Services that he was bad, that he was feeling pain and that it was bothering him (Tr 31). Petitioner denied telling the doctor at Tyler Medical Services on July 22, 2011 that he fell backwards and struck his right hand and wrist (Tr 31). He did complain of his left thigh and right wrist on that date (Tr 32). Petitioner did not remember telling the doctor at Tyler Medical Services on July 25, 2011 that he was walking without a limp

(Tr 32). He did not remember how many times he saw the doctor at Tyler Medical Services, but it was several times (Tr 33). Petitioner denied telling the doctor at Tyler Medical Services on July 29, 2011 that he was walking without any limp (Tr 33). Maybe he did see the doctor at Tyler Medical Services on August 11, 2011 and gave a history of discomfort from a hematoma on his left exterior thigh. Petitioner denied telling the doctor on that date that overall he was doing better (Tr 33). The hematoma was drained on August 1, 2011. Petitioner believed he saw Dr. Long at Tyler Medical Services on August 5, 2011, but did not remember telling Dr. Long that he felt capable of doing his regular duties at work. He wanted to go back to work because he was having issues with his house and did not want to lose his house (Tr 34). He did not remember being released to unrestricted work on August 5, 2011 (Tr 34-35). Petitioner believed that on that date, he was told to see Dr. Suchy for the hematoma (Tr 35-36). He saw Dr. Suchy at Tyler Medical Services on August 11, 2011 (Tr 37). Dr. Suchy took fluid from the hematoma on that date and took x-rays of his left hip (Tr 38). Dr. Suchy told him he was fine and always told him that he was okay (Tr 38-39). Petitioner believed Dr. Suchy again released him to unrestricted employment on August 11, 2011 (Tr 39). Dr. Suchy probably noted on August 11, 2011 that he had full range of motion of his left hip with no limping, but Petitioner did not remember (Tr 39-41). The Arbitrator allowed a break for Petitioner to walk around as he was obviously in pain (Tr 41-42). After the break, Petitioner testified that when he went to Tyler Medical Services in September 2011, they looked over the hematoma on his left thigh on September 15, 2011 and September 20, 2011 and decided there was not enough blood in the hematoma to take any fluid out (Tr 42). Petitioner believed he was discharged from treatment, but he did not remember (Tr 42). He continued working unrestricted through January 2012, but did not remember the dates (Tr 42-43). He worked for Respondent during this time (Tr 43).

Petitioner testified that he worked at a temporary agency through Caterpillar for 8 or 9 months (Tr 43). His employment with Respondent ended in October 2011, but he did not remember, but maybe yes (Tr 44). When he was seen at Tyler Medical Services on March 1, 2012, Petitioner gave a history that his left hip had been getting worse over the past few months (Tr 44). On March 11, 2012, Dr. Pappas at Tyler Medical Services probably noted that he was walking normally (Tr 44). Petitioner did not remember the dates and did not know if he saw Dr. Suchy on March 6, 2012 (Tr 44). Petitioner stated he has not walked normally since the date of accident (Tr 44). If the records for March 6, 2012 indicate he was walking without a limp, those records would be incorrect (Tr 44-45). Dr. Suchy probably told him on March 6, 2012 that he could return to work without restrictions (Tr 45). Dr. Suchy probably mentioned on that date that he needed no further treatment (Tr 45). Petitioner believed he saw Dr. Durkin at Hinsdale Orthopaedics on April 23, 2012 and gave a history of being injured in October 2011 (Tr 45-46). Petitioner returned to Hinsdale Orthopaedics on July 2, 2012 and saw Dr. Domb (Tr 46). He denied giving a history that his pain was mild at that time (Tr 46-47). On July 2, 2012, he gave a history of having problems walking. From the time of the accident, he always told the doctors he was having trouble walking (Tr 47). Petitioner denied that the history of walking problems on July 2, 2012 is different than what he told Tyler Medical Services in July, August and September of 2011 (Tr 47). He had been always telling them that he had been having problems (Tr 47). He told Dr. Domb on July 2, 2012 that his left hip had always been hurting (Tr 47-48). Petitioner

believed that on July 2, 2012, Dr. Domb released him to unrestricted work (Tr 48). He did not know which doctor took his restrictions off (Tr 48).

Petitioner testified he believed he returned to Hinsdale Orthopaedics on August 12, 2012. He did not remember if he had no treatment at Hinsdale Orthopaedics between July 2, 2012 and October 5, 2012 (Tr 48-49). On October 5, 2012, he told the physician's assistant that his pain was getting worse and that he was unable to work as a result of the pain (Tr 49). Petitioner acknowledged that this is probably different than what he told the physicians at Tyler Medical Services in July, August and September of 2011 when he was able to work (Tr 49-50). On October 5, 2012, he told the physician's assistant at Hinsdale Orthopaedics that he had trouble with activities of daily living and that he had trouble showering and putting on his shoes (Tr 50). Those are not different complaints than he had in July, August and September of 2011 and he has always been saying that the pain has been there (Tr 50). Before the accident, he did not have trouble showering and putting on his shoes (Tr 50). From the time of the accident up until now, Petitioner has always had those problems (Tr 50). The complaints he had on October 5, 2012 are probably different than the complaints he had when he saw Dr. Suchy on March 26, 2012 (Tr 51).

On re-direct examination, Petitioner testified that on August 5, 2011, he probably told Dr. Long that he was capable of returning to work. Dr. Long also referred him to a specialist (Tr 52). He was still under a doctor's care at Tyler Medical Services even though he requested a release to return to work (Tr 52). Petitioner was asked to assume that the medical records from Tyler Medical Services indicate in March 2012 that he was walking normally. Petitioner testified that at that time, he noticed very sharp left hip pain and pain all the way down his left leg (Tr 52-53). Petitioner testified he told the doctors at Tyler Medical Services in March 2012 that he still had these problems with his left hip and despite that, they still released him from care (Tr 53). He requested the release to return to work back in the summer of 2011 because of financial concerns (Tr 53-54). Even though he requested a release to return to work, his left hip was still painful (Tr 54). Returning to work had a big effect on his left hip and he felt like he was losing his strength and the pain was always there (Tr 54). He did discuss any problems he may have been having with his activities of daily living with the doctors at Tyler Medical Services (Tr 54-55). The temporary agency at Caterpillar is not Group O, but Petitioner's attorney has seen other clients call it that (Tr 55). When he went to doctors, he was able to tell these things as most of the times he used an interpreter (Tr 56).

3. According to the medical records from Tyler Medical Services, Px2, Petitioner saw Dr. Long on July 22, 2011. It was noted that Petitioner provided the following history through interpreters: "The patient was attempting to throw a metal bar above shoulder level that weighed approximately 100 pounds. He was assisted by two other coworkers. They lost control of the bar and it fell striking him along the bilateral anterior thighs and "rolled" down striking his right knee, distal lower extremity and foot. It did not strike his ankle. There was no blunt trauma distal to the left thigh. He then fell backwards and struck his right hand and wrist. He also has right elbow pain but does not know whether he struck it or not. There is no head trauma or loss

of consciousness." Petitioner reported pain at times involving the left thigh and right wrist to be 10/10. He had no complaints of numbness or tingling. Petitioner reported swelling and bruising of his right hand and that weightbearing and ambulating did produce pain of the lower extremities. He had no cervical, thoracic or lumbar pain. He reported no previous injury and no non-work related activity to precipitate the above. Petitioner complained of right wrist and left anterior thigh symptoms. On examination of the bilateral hips, Dr. Long found no palpable pain or tenderness on his right and there was palpable pain on the left greater trochanter and hip motion produced complaints of discomfort only with the left abduction. Dr. Long diagnosed, 1) right hand contusion; 2) right wrist contusion and sprain; 3) right elbow pain, probably secondary to contusion; 4) left hip contusion; 5) bilateral thigh contusions; 6) right knee contusion with abrasion; 7) right distal lower extremity contusion; 8) right foot contusion. X-rays were obtained of the right hand, wrist, left hip, bilateral femurs, right knee, right tibia and fibula and right foot and preliminary interpretation was negative for acute bony abnormalities. Petitioner's right elbow was Ace wrapped and his right wrist was splinted. He was prescribed medications and authorized off work.

Petitioner saw Dr. Beauvoir on July 25, 2011 and reported doing a little better. He rated his right hand, wrist and knee pain at 6/10, his left hip and right hip pain at 8/10 and his right elbow pain at 7/10. He had anterior left thigh bruising. It was noted that Petitioner had not been working as they had no work for him. Petitioner ambulated slowly, but with no limp. He was to continue prescribed medications, use ice/heat and do exercises twice daily. He was given work restrictions of no lifting more than 10 pounds, no push/pull over 10 pounds, stoop/bend as tolerated and limit climbing to stairs. On July 29, 2011, Petitioner reported to Dr. Beauvoir that his elbow, knee and foot were doing better. His bilateral thighs and hip areas continued to bother him. There were left exterior thigh fluid waves. On examination, Dr. Beauvoir found that the left hip proximally and laterally revealed some ecchymosis, as well as medially and there was also a fluid collection in that area in what appeared to be surrounding by a hematoma. Dr. Beauvoir diagnosed multiple contusions and left hip swelling and pain. Dr. Beauvoir prescribed a left thigh ultrasound to rule out deep vein thrombosis. The ultrasound was performed and no deep vein thrombosis was noted, but further examination of the fluid collection revealed a liquefying hematoma 4.4cm wide and 5mm deep. Dr. Beauvoir prescribed medications and Petitioner's work status remained the same.

On August 1, 2011, Petitioner reported to Dr. Beauvoir that he was doing better overall, but had some discomfort with the left thigh hematoma, especially when clothes rubbed against it. Otherwise, he stated he was doing better with his hips, thighs, wrist and knee. There was no numbness, tingling or radiation of pain to the lower extremities bilaterally. Petitioner ambulated with no limp or antalgic gait. Petitioner requested drainage of the hematoma, which was performed. Dr. Beauvoir prescribed physical therapy. In his Initial Evaluation that same day, the physical therapist noted that on examination, Petitioner's right hip was restricted secondary to complaints of pain in the groin and lateral leg and his left hip was within normal limits. The therapist recommended physical therapy three times a week for two weeks.

Petitioner reported to Dr. Beauvoir on August 5, 2011 that he felt much better. Petitioner reported he had attended physical therapy and felt he continued to get better and capable of doing his regular duties at work. Petitioner requested to be seen by a specialist for the hematoma. It was noted that he ambulated with no limp or antagic gait. It was also noted that Petitioner had completed physical therapy and felt capable of doing home exercises. Dr. Beauvoir referred Petitioner to orthopedic specialist Dr. Suchy for further evaluation and possible incision and drainage of the left thigh hematoma. Dr. Beauvoir found there were no limitations of Petitioner's work status.

Petitioner saw Dr. Suchy on August 11, 2011 and an interpreter was used. Dr. Suchy noted, "The patient presents for initial orthopedic consultation in regards to an injury to the lateral aspect of his left hip." The following history was noted: "The patient is a 55-year-old male who states he was injured on 7/22/11, when a bar weighing at least 100 pounds fell and struck his helmeted head and fell on the left side of his left elbow and left thigh area." Petitioner complained mostly now of pain over the lateral aspect of his left thigh. X-rays were taken of the left hip and were negative. Dr. Suchy's impression was traumatic hematoma of the left hip. Dr. Suchy drained fluid from the hematoma. Dr. Suchy discontinued physical therapy and released Petitioner to regular duty work.

Petitioner saw Dr. Long on September 15, 2011 for an unscheduled visit and an interpreter was used. He had missed a September 7, 2011 appointment with Dr. Suchy. Petitioner presented because he felt there may be accumulation of the "blood" again. Petitioner reported he had been having tenderness as he had increased his activity with his left lower extremity and rated his pain at 3/10. He had no complaints of numbness, tingling or noticeable weakness. He had noticed tenderness in the left testicular area, but had no complaints of groin pain. He reported no new injury since his last evaluation. On examination, Dr. Long found no evidence of soft tissue prominence or evidence of hematoma formation; there was tenderness, but not pain, over the anterior aspect of his left thigh; there was no pain involving the left hip or knee; left hip and knee motion presented with firm end points and no complaints or referred symptoms; strength was 5/5 throughout; and he ambulated without antalgic gait. Dr. Long diagnosed status post left hip contusion and hematoma with aspiration. Dr. Long scheduled Petitioner an appointment with Dr. Suchy. Dr. Long instructed Petitioner to contact his primary care physician for his urinary complaints and left epididymis findings and Dr. Long was not able to correlated these symptoms with Petitioner's work related injury of July 22, 2011. He noted Petitioner's work status as having no limitations.

Dr. Suchy noted he saw Petitioner on September 20, 2011 and an interpreter was used. Petitioner presented for follow up of left thigh hematoma aspiration. Petitioner reported he was doing well after the aspiration, but felt there may be some recurrence of fluid. On examination, Dr. Suchy found very little, if any, recurrence of fluid and it was a very small amount and he did not think it was necessary to aspirate this. Dr. Suchy noted that he explained to Petitioner that if it gets worse, he would be glad to re-evaluate it. Otherwise, Petitioner was to be seen as needed. Dr. Suchy noted Petitioner's work status as regular activities without restrictions.

On March 1, 2012, Petitioner saw Dr. Pappas, who noted that an interpreter was used. Dr. Pappas noted that Petitioner presented for a re-open of left hip injury. The following was noted: "Patient states that when he last saw Dr. Suchy on 9/20/11, he was feeling better still having some slight hip discomfort." The Commission notes that slight hip discomfort was not mentioned in September 20, 2011 records. It was further noted: "He states this has gradually gotten worse over the last few months." Petitioner reported that his pain at rest was rated at 2/10, but with bending and certain movement his pain was 6/10. Petitioner described the pain as throbbing and the location of pain was the left hip region over the greater trochanter region. Petitioner felt like there was a "small ball" in this area. Petitioner denied any new injury or re-injury of this area. Petitioner reported that when he was released from care by Dr. Suchy on September 20, 2011, he was back at work doing his regular job up until January 2012 and since then he had not been working. On examination of the left hip, Dr. Pappas found some palpable tenderness in the lateral hip region, range of motion was within normal limits throughout the left hip, with complaints of increased discomfort with all end point ranges. X-rays of the left hip were taken and preliminary interpretation was negative for acute osseous pathology. Dr. Pappas diagnosed left hip pain and prescribed medications. Dr. Pappas noted Petitioner was walked over to the therapy department for demonstration of home exercises, which he should do twice daily. He was to alternate ice and heat twice daily for 15 minutes. Dr. Pappas referred Petitioner to Dr. Suchy. Petitioner was not given any restrictions.

Petitioner saw Dr. Suchy on March 6, 2012 and it was noted that an interpreter was used. Petitioner complained of left hip pain. Dr. Suchy noted his treatment on September 20, 2011. Petitioner reported that when he did certain squatting or lifting heavy objects, he felt like the bones were pulling apart. On examination of the left hip, Dr. Suchy found that Petitioner ambulated without an antalgic limp, that he was able to squat down without difficulty, he had full range of motion, negative Faber's test of the hips, the pelvis had no pain with pelvic rock, there was no swelling, the abductor and extensor muscles were functioning and that the examination was essentially without any objective findings. Dr. Suchy reviewed the x-rays of the hips and pelvis, which were normal. Dr. Suchy's impression was status post contusion left hip area. Dr. Suchy opined that there was no objective reason why Petitioner could not perform his regular activities without restrictions. Dr. Suchy opined that Petitioner did not need any further diagnostic studies or therapy modalities. Dr. Suchy noted that Petitioner stated he was not currently working because he had been laid off because of some union issues. Dr. Suchy opined Petitioner was at maximum medical improvement.

4. According to Hinsdale Orthopaedics medical records, Px3, Petitioner saw Dr. Durkin on April 3, 2012. The following history was noted: "He is a gentleman who was injured in October of last year when he was lifting a very heavy item onto a truck and it fell backwards on him. It hit him in the upper left thigh and he was knocked to the ground, took a nasty tumble. He has been sore ever since. The pain, he rates as quite high. It hurts when he walks." The Commission notes that the date of accident was July 22, 2011, not October 2011. On examination, Dr. Durkin found the pain was anterior, radiated down to the side of the hip, sometimes in the back with leg flexion and pain with hip range of motion. X-rays of the back

were essentially normal. X-rays of left hip showed there was some small spurring in the hip joint and Dr. Durkin opined this was probably not related to the injury described. Dr. Durkin noted that overall Petitioner had some pain with hip rotation, flexion, internal and external rotation. Dr. Durkin opined Petitioner may have some impingement, some soft tissue damage. Dr. Durkin noted, "He would benefit from an MR arthrogram of this hip to evaluate for the labrum given the nature of this very heavy object falling on him and knocking him over, and hitting him in the hip physically." Dr. Durkin ordered a left hip MR arthrogram. He discussed this with Petitioner to the best of his ability in Spanish.

A left hip MR arthrogram was performed on April 17, 2012. The radiologist's impression was partially detached tear of the anterosuperior labrum. There was mild diminution of the anterior labrum, which demonstrated an area of mild irregularity/partial detachment. There was mild left hip degenerative joint disease with early femoral collar osteophytes and a small cyst present at the femoral head/neck junction. It was noted that Petitioner did report a slight interval improvement in left hip pain following the intraarticular administration of ropivacaine.

5. According to Hinsdale Orthopaedics medical records, Px5, Petitioner saw Dr. Durkin on May 25, 2012 for complaints of his left hip. Petitioner reported significant pain when working and it bothered him on a regular basis with any prolonged walking, twisting and raising his legs. On examination of Petitioner's left hip, Dr. Durkin found mild tenderness over the greater trochanter; pain with range of motion; flexion to 110 degrees, internal rotation to 30 degrees, external rotation to 40 degrees, abduction to 50 degrees; strength 4+/5; positive labral impingement test; Faber's present. Dr. Durkin reviewed the left hip MR arthrogram disc, which showed a significant anterior superior labral tear. Dr. Durkin opined Petitioner's physical examination correlated well with the MR arthrogram findings, as did his symptoms. Dr. Durkin referred Petitioner to Dr. Domb for further left hip treatment. Dr. Durkin noted he discussed arthroscopy with Petitioner to the best of his ability in Spanish. Dr. Durkin placed Petitioner on light duty work status with minimal walking. Petitioner was to be seen as needed.

On July 2, 2012, Petitioner saw Dr. Domb for complaints of left hip pain. The following was noted: "he was injured on October 2011, when a heavy object fell on him. It hit him in the left thigh and he fell to the ground." The Commission notes that the date of accident was July 22, 2011. Petitioner reported anterior hip pain, aggravated by walking and movement. The pain was mild to moderate, but stated he felt that the hip was unstable. On examination of the left hip, Dr. Domb found a left antalgic gait; flexion was 100 degrees with pain, internal rotation to 30 degrees, external rotation to 40 degrees, abduction to 50 degrees; there was tenderness of the greater trochanter, piriformis and groin; anterior impingement test was positive; lateral impingement test was positive; Faber sign was positive. On examination of the right hip, Dr. Domb found flexion to 120 degrees, internal rotation to 30 degrees, external rotation to 50 degrees and abduction to 50 degrees. Hip x-rays were done and reviewed and showed joint spaces were intact bilaterally and were relatively normal, bilateral Cam lesions and Alpha angle greater than 50 degrees. Dr. Domb reviewed the MR arthrogram, which showed an

anterosuperior labral tear with partial detachment. Dr. Domb's assessment was a left hip labral tear caused by work injury where a beam fell on his lap essentially. Dr. Domb noted this had been painful for 9 months and failed to improve with physical therapy and his pain was very severe. Dr. Domb opined, "Notably, he does have some Cam morphology which was not caused by the work injury. However, if not for the work injury, he would not likely currently be suffering this condition and therefore this is a work-related problem." Dr. Domb prescribed physical therapy and noted that if there was no improvement in the near future, he would consider arthroscopy. Petitioner was not given any work restrictions.

Petitioner saw Julie Morgan PA-C on October 5, 2012 and reported his left hip pain was getting worse. Petitioner reported his left hip pain was moderate and he was unable to work due to the pain. He had not attended physical therapy. His pain was affecting activities of daily living and he had difficulty with putting on his shoes. It was noted that Petitioner was let go from his job because he could not work with the pain. It was noted Petitioner also had lumbar pain and numbness of the soles of both feet and that this started when he was injured at work. On examination of the left hip, Ms. Morgan found left antalgic gait; flexion to 80 degrees with pain, internal rotation to 10 degrees with pain, external rotation to 30 degrees with pain, abduction 30 degrees with pain; straight leg raises caused post hip pain, but no radiculopathy; there was a positive anterior impingement test; there was a positive Faber's sign. Ms. Morgan's impression was: 1) left hip pain with left hip labral tear caused by work injury with failure to improve and pain is fairly debilitating; 2) lumbar pain with numbness at the bottom of the soles of both feet. Ms. Morgan recommended obtaining a lumbar MRI to rule out any lumbar spine pathology and physical therapy. Ms. Morgan noted surgery had been denied previously by the workers' compensation insurer. Ms. Morgan placed Petitioner on modified work status, sedentary work only. On October 10, 2012, Dr. Domb ordered a lumbar MRI and physical therapy for Petitioner's left hip.

Petitioner saw Dr. Zindrick on November 21, 2012 at Dr. Domb's request and it was noted that an interpreter was used. Dr. Zindrick noted that Petitioner was there due to a work related injury that began in July 2011. Dr. Zindrick noted a history that in July 2011, Petitioner bent over to lift a 30 pound piece of wood. When he went to stand back up, he developed immediate low back pain. He was sent to the company doctor and was told everything was okay, but he was able to take a week or two off work. He rested and followed up and was sent back to work. He had some ongoing pain but had not had any treatment for his back. The Commission notes that this is a different history than previously noted. Dr. Zindrick noted that Petitioner was seeing Dr. Domb for left hip pain and was referred for evaluation of low back pain and pain radiating into his legs. Petitioner reported his pain was 25% in his back, 75% in his legs with the left leg worse than the right leg. The pain fluctuated from his back to his left hip and Petitioner reported this had been present ever since the work related injury. Petitioner denied any back problems prior to this injury. Dr. Zindrick reviewed the lumbar MRI scan, which demonstrated multi-level disc desiccation and degeneration with disc bulging and moderate central canal stenosis with mild foraminal narrowing at L4-5 and minimal grade 1 anterolisthesis at L5-S1 with a shallow disc bulge. Dr. Zindrick's impression was low back pain with radiculopathy left

greater than right with underlying multilevel degenerative disc disease and spinal stenosis, most prominent at L4-5. Dr. Zindrick ordered physical therapy for the back and prescribed medications. Dr. Zindrick opined Petitioner was capable of returning to work as per Dr. Domb's previous work restrictions.

6. Hinsdale Orthopaedics medical records, Px4, indicate Petitioner saw Dr. Zindrick on January 7, 2013 and an interpreter was used. Petitioner reported 75% back pain, 25% left buttock and leg pain, which he rated at 5-7/10, no better, possibly worse. Petitioner reported his pain was aggravated by walking, lying down and lifting and he was better sitting. Petitioner reported that in physical therapy, he had some increased discomfort in his chest which he related was due to his October 2011 lifting/falling incident documented in Dr. Durkin's note that improved, but then had been aggravated. On examination, Dr. Zindrick found tenderness along his sterna costal junction and xiphoid. Dr. Zindrick's impression was: 1) costochondritis; 2) ongoing back pain with lumbar radiculopathy. Dr. Zindrick recommended Petitioner remain off work, continue prescribed medications and an epidural steroid injection at the L4-5 level.

7. At Respondent's request, Petitioner saw Dr. Stover for a §12 evaluation on January 16, 2013. In his report of that date, Rx1, DepEx2, Dr. Stover noted the following history: "He reports to me that in July 2011, he was lifting an object with colleagues. It weighed over 100 pounds. It was about at shoulder height and somewhat like a metal bar. They lost control of it. It fell. It hit his helmet, his chest, and his legs and rolled down his body. He felt his whole body was on fire." Petitioner reported he currently felt weak on the left side and when he pivoted on his left leg, he was unstable. Petitioner reported that he had no change in his pain since the beginning. Petitioner reported he also had some low back pain. On examination, Dr. Stover found that Petitioner walked with a variable cadence gait and it appeared he was somewhat antalgic; there was no evidence of any bruising, contusions or asymmetrics of the thigh; no obvious atrophy of the left thigh versus the right; he had sciatic notch tenderness, SI joint tenderness and greater trochanteric tenderness on the left; he was unable to adequately flex his hip or lift it off the bed; he could abduct against gravity, but had giving way secondary to pain; flexion was at 95 degrees, internal rotation at 15 degrees, external rotation at 40 degrees with complaints of pain in the end range in the anterior aspect of the joint consistent with anterior impingement and hyperflexion with subspine area impingement. Petitioner brought the MR arthrogram scan with him and there were no plain x-rays or MRI of the left hip. Dr. Stover reviewed the medical records of Tyler Medical Services and Hinsdale Orthopaedics and noted the left hip MR arthrogram results. Dr. Stover diagnosed, 1) left hip pain with hip impingement; 2) low back pain. Dr. Stover recommended that Petitioner be further evaluated for a possibility of left hip arthroscopy and the possibility of an epidural steroid injection to the spine.

Dr. Stover opined that he did not believe that the July 22, 2011 incident caused Petitioner's labral tear. He slso did not believe that the injury was the cause of his continuing symptoms. Dr. Stover opined that with Petitioner's age and femoral morphology, a labral tear would be expected to be found on MRI. Dr. Stover opined that the medical records show that Petitioner did not complain of specific hip joint type of complaints following the injury. Dr.

Stover opined that Petitioner sustained a contusion to the anterior aspect of his thigh and lateral aspect of his hip, which was subsequently drained. Dr. Stover was uncertain as to the rationale for Petitioner's appearance at Hinsdale Orthopaedics and from that point on he was found to have a painful range of motion of his left hip. Dr. Stover noted that Petitioner reported a partial improvement of his symptoms with a hip injection during the MR arthrogram. Therefore, Dr. Stover did not believe that Petitioner's left hip is the complete source of his discomfort and/or current situation of ill-being. Dr. Stover opined that it is more probable that Petitioner slowly developed over time a degenerative labral tear secondary to his femoral morphology and this became symptomatic following the injury. Dr. Stover did not believe that the injury rendered the hip symptomatic nor did he believe that it caused a labral tear or his femoral morphology. Dr. Stover also did not believe that the injury will change the natural history course of his hip.

Dr. Stover noted that Petitioner sustained a low back strain on April 6, 2011 and that he had a symptomatic temporary exacerbation of pain in his back at that time. Dr. Stover did not believe that the April 6, 2011 incident caused degeneration of his lumbar spine and/or the current symptoms that he is experiencing. Dr. Stover noted the long period of time between the initial injury on April 6, 2011 and the subsequent presentation with back pain and numbness into his feet. Therefore, Dr. Stover did not feel that the incident of April 6, 2011 represented a permanent injury and/or change in his pain or neurologic status. Dr. Stover opined Petitioner could return to work with possible modified duty due to his current back pain and hip problems. Dr. Stover opined Petitioner could undergo a hip arthroscopy and possible treatment of the hip impingement, but did not believe this is a work related injury and/or symptomatic exacerbation of a preexisting condition or symptomatic presentation of a preexisting condition and therefore, he did not feel that the surgery should be compensable. Dr. Stover opined that as with any low back strain and failure of physical therapy, Petitioner would also benefit from the possibility of epidural steroid injections, but he did not believe this is related to his work incident and therefore, is not compensable.

8. On February 6, 2013, Petitioner saw Dr. Zindrick and it was noted that an interpreter was used. Petitioner reported his back and leg symptoms were unchanged. It was noted that no epidural steroid injection had been done. Petitioner reported 80% low back pain and 20% leg pain, which he rated at 6-8/10. His pain was worse with prolonged positioning and lifting and better with changing positions. Petitioner reported numbness and tingling in his left leg. Petitioner also complained of right elbow pain in the olecranon area which he related back to his work related injury; pain was off and on, but not better. He was not working. Dr. Zindrick's impression was ongoing back pain and left leg pain, epidural steroid injection pending. Petitioner was to remain off work and an epidural steroid injection was to be arranged. Petitioner was referred to Dr. Fajardo for an elbow evaluation.

Petitioner saw Dr. Zindrick on April 1, 2013 and an interpreter was used. Petitioner reported continued pain, 50% low back pain and 50% pain into his legs, rated at 6-8/10. Dr. Zindrick noted that epidural steroid injections were not approved. Petitioner had not seen Dr. Fajardo. Dr. Zindrick's impression was low back pain and bilateral leg pain. Petitioner was to

remain off work. He was to follow up with Dr. Krincic for further conservative management and was to follow up with Dr. Zindrick on a when necessary basis. Dr. Zindrick still recommended epidural steroid injection. (Px4).

9. During his June 11, 2013 deposition, Px1, Dr. Domb testified he is a board certified orthopedic surgeon with a specific subspecialty in hip injuries and hip arthroscopy. Dr. Domb recited from his records, which are noted above. Dr. Domb testified he first saw Petitioner on July 2, 2012. At that time or close to that time, Dr. Domb did not review any other medical records (Dp 8). He reviewed x-rays that were taken that day and a MR arthrogram from April 17, 2012 (Dp 8). Dr. Domb did see Dr. Durkin's records (Dp 8). The MR arthrogram revealed an anterior superior labral tear with partial detachment. Dr. Domb described the labrum as a ring of fibrocartilage surrounding the edge of the acetabulum or socket; in laymen's terms, it seals the ball in the socket and seals the lubricant fluid between the ball and socket (Dp 9). Dr. Domb opined that there is nothing about the MRI appearance of such a tear which could indicate that the tear was acute or chronic (Dp 9). Petitioner reported to him that his injury was in October 2011 (Dp 9). He reported he had symptoms since the injury (Dp 10). Petitioner did not tell him about any problems he had with his hip that predated that time (Dp 10). If the records show that the incident actually occurred in July 2011 and not October 2011, this would not in any way change his conclusions (Tr 10). Dr. Domb was informed on the day of this deposition by Petitioner's attorney that Petitioner had a hematoma following this July 2011 incident and received treatment for same (Dp 10). His examination findings were consistent with the MR arthrogam findings (Dp 12). Dr. Domb explained that Cam morphology is a description of the femoral head ball and indicates that the ball is not perfectly round (Dp 12). Some degree of Cam morphology will be seen in most hips and most people do not get hip pain (Dp 13). There is no direct relationship between the Cam morphology and the labrum. The labrum is the edge of the socket and seals the ball in the socket. Dr. Domb testified, "When a labrum is torn and we repair it, then, often we will reshape a femoral head to make sure it as close to spherical as possible in order to avoid any load or friction against the area where the labrum was injured and subsequently repaired." (Dp 13). The surgery he recommended consists of a left hip arthroscopy with repair of the labral tear and reshaping of the femoral head ball (Dp 14).

Dr. Domb opined that the labral tear is causally related to the work accident of July 22, 2011 (Dp 14). Dr. Domb opined, "The most notable link between the work injury and his labral tear is the temporal relationship between the injury and his onset of pain. He did not, to my knowledge, have any problems with his hip prior to his injury, and subsequent to his injury he developed a painful hip. The most likely link, therefore, is damage to the soft tissue as in the labrum." (Dp 14). Dr. Domb opined that the Cam morphology was neither new nor a cause of his problem (Dp 14). Dr. Domb opined that the Cam morphology had been present through Petitioner's entire adult life and he has similar Cam morphology on both sides (Dp 14-15). Dr. Domb stated that his recommended surgery is analogous to when he does a rotator cuff repair he frequently does a subacromial decompression, a reshaping of the undersurface of the acromion, to avoid any compression against the repaired area of the rotator cuff (Dp 15). Dr. Domb opined that if not for the work injury, Petitioner would not currently be suffering this condition (Dp 16).

Dr. Domb opined that if Petitioner had not been injured at work, he would still have no hip problem (Dp 16). Dr. Domb opined that the hip injury itself led to the need for surgery (Dp 16). Dr. Domb only saw Petitioner on July 2, 2012. Petitioner did see his Physician Assistant Julie Morgan on October 5, 2012. Dr. Domb recited Ms. Morgan's October 5, 2012 notes.

Dr. Domb did review §12 Dr. Stover's January 16, 2013 report. Dr. Domb noted that both he and Dr. Stover agree that Petitioner needs surgery (Dp 19). Dr. Stover had opined that Petitioner would have needed surgery in any event. Dr. Domb noted that Petitioner had Cam morphology on both sides. He noted that Dr. Stover concluded that anyone with Cam morphology would get a labral tear and get a painful hip. Dr. Domb noted that Petitioner had not developed a labral tear or a painful hip on the other side proves that is not the case (Dp 19). Dr. Domb opined that the only difference between Petitioner's hips which has caused him to develop a painful hip on the left side is the fact that he had an injury there (Dp 20). Dr. Domb would not recommend any treatment for Petitioner's right hip because Cam morphology is not a pathologic finding and it is a normal finding which is present in the majority of the population (Dp 20). Dr. Domb opined that a 5½ gap in treatment between September 2011 and March 2012 would not in any way change his opinion regarding causation (Dp 20). This gap would only indicate to him that Petitioner was a hard working gentleman who wished to return to work and tried to do so despite his pain and while attempting to work did not seek medical care for a period of time (Dp 21). Assuming Petitioner presented to him this day with the same symptoms as he presented the last time he saw him, Dr. Domb would still be of the opinion he would be a candidate for hip surgery (Dp 21).

On cross-examination, Dr. Domb opined that a 50 year old laborer such as Petitioner could have a labral tear without trauma (Dp 22). Dr. Domb had reviewed the x-rays and did not see any osteophytes (Dp 23). If Dr. Durkin's chart says that, Dr. Domb would disagree that there are any osteophytes (Dp 23). Dr. Domb reviewed his notes of July 2, 2012 and noted that under the review of systems section in his office notes, Petitioner denied back pain (Dp 23-25). Petitioner's straight leg raises that day were negative. Dr. Domb did not give Petitioner work restrictions on July 2, 2012 (Dp 25).

On re-direct examination, Dr. Domb testified that he uses a computer program to run his office notes. With respect to the review of systems section, there are a number of default findings; a patient has to indicate something different than the defaults in order to produce something in the report that is different from the template. The template under the musculoskeletal system as seen in Petitioner's report with no changes having been made to the musculoskeletal template or defaults under the review of systems, it reads denies back pain, joint pain, joint swelling, muscle cramps, muscle weakness, stiffness or trouble walking. Obviously, that section of the review of systems was not addressed by the patient since he was indeed complained of joint pain and trouble walking at that time (Dp 28-29). Petitioner did not address that portion of his questionnaire during the admission process and likely left it blank and therefore, the defaults were left in the templates (Dp 29).

On re-cross examination, Dr. Domb testified that he is quite certain from the history that he and Petitioner did not discuss whether he had back pain or not. Petitioner was there to see him for hip pain (Dp 30). Dr. Domb did not have an independent recollection of the history in the patient's statements of complaints regarding back pain on July 2, 2012 (Dp 30). Dr. Domb did not see Petitioner for his back (Dp 30).

10. During his September 4, 2013 deposition, Rx1, §12 Dr. Stover testified that he is a board certified orthopedic surgeon. Ninety-five percent of his practice consists of treating patients and five percent involves medical/legal issues for litigation. Dr. Stover recited from his report, noted above. Dr. Stover gave the same opinions as noted in his report. Dr. Stover opined that the July 22, 2011 incident did not cause Petitioner's labral tear, based mainly on the lack of some of his symptoms following his initial injury (Dp 12-13). Petitioner did not have symptoms consistent with an intra-articular process of the hip (Dp 13). Dr. Stover described Cam morphology the same as Dr. Domb had (Dp 14-15). Dr. Stover noted that Petitioner did not have specific hip joint type complaints after the July 22, 2011 injury (Dp 16-17). There is literature that says that most patients will have some kind of a groin component of their pain when they have intra-articular pathology; they may also have pain in the outer aspect of the hip and may also have pain in the buttock or in the knee or anterior thigh, but over 95% have some component of groin pain. There was no documentation in the early aspect of Petitioner's treatment following the injury of his complaints that would point towards his hip; there were no examination findings that would point towards his hip as a potential source of pathology. Dr. Stover did not see any real concern by any of Petitioner's treaters that his hip was the cause of his pain (Dp 18). Dr. Stover opined that degenerative labral tears occur without any trauma (Dp 20). Labral tears can occur without pain (Dp 20). Dr. Stover opined that he did not know if Petitioner developed a degenerative labral tear over time; the question is whether or not he developed symptoms over time that were consistent with an intra-articular problem in the hip (Dp 22). Dr. Stover opined that the work accident did not cause Petitioner's left hip to become symptomatic sooner (Dp 22). Dr. Stover opined that there was no causal relationship to the July 22, 2011 accident (Dp 23).

On cross-examination, Dr. Stover testified that based on his interaction with Petitioner and his review of the medical records, he would not agree that Petitioner had complained of some left hip pain since his accident (Dp 29). Petitioner did tell him he had left leg pain and that it did not change over time and based on the medical records, there was a change in his symptoms over time (Dp 30). Petitioner was not specific as to hip pain (Dp 30). Dr. Stover would agree that presently Petitioner could benefit from further treatment and evaluation to both his left hip and lumbar spine (Dp 31). Dr. Stover did not examine Petitioner's right side (Dp 31). There was no documentation that Petitioner had received treatment for right-sided leg or right hip pain (Dp 31). Dr. Stover opined that it would not be unusual for Petitioner to have Cam morphology bilaterally (Dp 32). Petitioner is only currently symptomatic on his left side (Dp 32). On Page 3 of his report, Dr. Stover stated that Petitioner was uncertain for his rationale for going to Hinsdale Orthopaedics; Dr. Stover acknowledged that Petitioner was having pain (Dp 32). There was nothing that he saw in the medical records indicating Petitioner was having

pain in his left hip prior to the July 22, 2011 accident (Dp 32). Dr. Stover's work-up found some left-sided pathology (Dp 32). Dr. Stover agreed that Petitioner needs further evaluation (Dp 33). Petitioner did not tell him why he went to Hinsdale Orthopaedics (Dp 33). Dr. Stover opined that it is possible that the physicians at Tyler Medical Services missed Petitioner's left hip problem and that anything is possible (Dp 34). In young patients with hip pain, 95% of the time there is also an association with groin pain (Dp 34). Petitioner clearly suffered a trauma to his left leg (Dp 36). Petitioner complained of his left thigh and wrist pain on July 22, 2011 (Dp 36). Petitioner did report to him a history of left hip pain since the accident (Dp 36). Dr. Stover would agree that Petitioner suffered at least a back strain as a result of the work injury on April 6, 2011 (Dp 38). Dr. Stover opined that trauma can cause or aggravate a labral tear, making it symptomatic and therefore, leading to the need for treatment (Dp 39-40). Dr. Stover had no opinion as to whether Petitioner has a similar Cam morphology on the right side (Dp 40).

On re-direct examination, Dr. Stover testified that his opinions and conclusion on this day were the same as in his report (Dp 41).

11. According to Hinsdale Orthopaedics medical records, Px6, Petitioner saw Kinzie Sharp PA-C on October 1, 2013 for recheck regarding his left hip pain. Ms. Sharp noted that Petitioner was last seen by Dr. Domb on July 2, 2012 and he recommended arthroscopic surgery at that time. She also noted that Petitioner had also been treating with Dr. Zindrick for his back. Dr. Zindrick had recommended conservative treatment with Dr. Kirincic for his back. Petitioner reported that both his hip and back pain were bothersome. Petitioner was not working. He reported he was hoping to complete a functional capacity evaluation for permanent restrictions and avoid surgery, but he still had significant hip and groin pain and decreased range of motion. He also complained of numbness and tingling down the left leg and down to the bilateral feet. Ms. Sharp assessed a left hip known labral tear caused by an injury at work. Petitioner was to follow up with Dr. Domb for surgical recommendation and to discuss with him if a functional capacity evaluation was an option. Ms. Sharp noted that Petitioner was not at maximum medical improvement as surgery had been recommended. Petitioner was also to follow up with Dr. Kirincic for his back as per Dr. Zindrick. Ms. Sharp gave work restrictions of no lifting more than 5 pounds, no prolonged sitting/standing/walking and no bending/kneeling/squatting.

Petitioner saw Dr. Kirincic on October 9, 2013 and an interpreter was used. He had been referred by Dr. Zindrick for follow up for low back and left leg pain. Dr. Kirincic noted a history of a work injury picking up a bundle of wood in April 2011 or 2012 and a second injury when a beam fell on his head in June 2012. The Commission notes that this is a different history than previously noted. Petitioner reported constant pain across his low back, which traveled up his spine and to his left posterolateral hip. He reported intermittent pain in his inner and lateral thigh with standing/walking/sitting. He also reported numbness and tingling throughout his entire left lower extremity with sitting more than 5 minutes, alleviated with standing/walking. He rated his pain at 6/10 and 8-9/10. His pain was aggravated with yardwork, walking and prolonged sitting and aleviated with positional changes and massages by his wife. Petitioner also complained of his right elbow, left knee, bottom right foot and area of xyphoid process which had not been

addressed. Petitioner reported he was referred by Dr. Zindrick in April 2013 and it took 6 months to secure a consultation. Petitioner reported he was not currently interested in the surgery recommended by Dr. Domb. Dr. Kirincic ordered physical therapy.

Petitioner saw Dr. Domb on October 24, 2013 for complaints of left hip pain, which he reported had not changed. He also reported persistent low back pain and radiculopathy. Dr. Domb's impression was 1) low back pain with radiculopathy; 2) left hip labral tear caused from work related injury with Cam morphology. Due to the failure of physical therapy, Dr. Domb again recommended left hip arthroscopy. Dr. Domb opined Petitioner was unable to return to work. Petitioner was to follow up with Dr. Zindrick for his lumbar spine and radiculopathy.

Dr. Zindrick saw Petitioner on November 12, 2013 and noted that he saw Dr. Kirincic once and did not follow up with her. Dr. Zindrick noted Petitioner had surgery for his left hip pending with Dr. Domb. He was not working and was attending physical therapy. Petitioner reported 80% back pain and 20% constant leg pain, left greater than right. He rated his pain at 6-8/10. Dr. Zindrick's impression was spinal stenosis L4-5 with bulging disc, disc degeneration L4-5 and L5-S1, back pain and leg pain. Dr. Zindrick prescribed medications and continued physical therapy. Dr. Zindrick opined Petitioner was unable to return to work.

Petitioner underwent a functional capacity evaluation on December 17, 2013 performed at ATI. Petitioner demonstrated functional capabilities at the light to medium physical demand level. He was capable of desk to chair lifting of 52.8 pounds occasionally, chair to floor lifting of 45.6 pounds occasionally and lifting of 28.6 pounds above the shoulders bilaterally occasionally.

Petitioner saw Dr. Zindrick on January 22, 2014 and an interpreter was used. Petitioner complained of ongoing pain in his back, legs and left hip. He reported 70% pain in his back, 30% pain in his left hip and bilateral legs with some numbness and tingling. He had no new symptoms. Dr. Zindrick noted Petitioner recently underwent a functional capacity evaluation, had finished physical therapy and was not taking pain medications. Dr. Zindrick reviewed the functional capacity evaluation report. On examination, Dr. Zindrick noted complaints of pain with range of motion of the lumbar spine and good strength into his legs and feet bilaterally. Dr. Zindrick's impression was low back pain with radiculopathy and also with left hip pain. Petitioner was to follow up with Dr. Domb for his left hip. He was to continue home exercises. Dr. Zindrick released Petitioner to work as per the functional capacity evaluation of light medium work from a spinal perspective. Other restrictions were to be per Dr. Domb. Petitioner was to return to see Dr. Zindrick as needed. He was also to follow up with Dr. Kirincic as needed for further pain management.

12. Petitioner's attorney submitted the following medical bills and they were admitted into evidence:
Px8: Aurora Radiology Consultants 7-29-11: $250.00;
Px9: Hinsdale Orthopaedics 10-5-12 through 1-22-14: total charges: $5,565.00.

Based on the record as a whole, the Commission reverses the Decision of the Arbitrator finding that Petitioner failed to prove that a causal relationship exists between those injuries sustained on July 22, 2011 and his current condition of ill-being and denies Petitioner's claim. The parties stipulated to the July 22, 2011 accident. The medical records of Tyler Medical Services indicate that Petitioner did have some initial complaints of his left hip on July 22, 2011, among other complaints, and on subsequent visits. Then the focus became on his left thigh hematoma, which was aspirated. There was no further mention of his left hip in the medical records until March 1, 2012, when Petitioner reported to Dr. Pappas that when he had last seen Dr. Suchy on September 20, 2011, he was still having some slight left hip discomfort. This was not noted in Dr. Suchy's September 20, 2011 records. Petitioner further reported to Dr. Pappas on March 1, 2012 that his left hip pain gradually got worse over the last few months. There was a five and a half month gap between September 20, 2011 and March 1, 2012. Petitioner testified that he had continuing left hip pain during this gap, yet he did not seek treatment.

Lumbar complaints were not mentioned in the medical record until October 5, 2012. Petitioner gave a history of low back pain and left leg pain since the July 22, 2011 accident to Dr. Zindrick on November 21, 2012, but he had not mentioned this before, according to the medical records. The parties agreed that this case is only dealing with Petitioner's left hip.

Dr. Domb opined causal connection for the left labral tear to the July 22, 2011 accident. Dr. Domb also opined that Petitioner had some Cam morphology which was not caused by the work injury, but if not for the work injury, Petitioner would not likely be suffering this condition and therefore this is a work related problem. The Commission notes that the history Petitioner reported to Dr. Domb was that he was injured in October 2011 when a heavy object fell on him and hit him in the left thigh and he fell to the ground. The accident was actually occurred on July 22, 2011. In his deposition, Dr. Domb acknowledged that he had not reviewed medical records, other than those of Dr. Durkin and the April 17, 2012 MR arthrogram.

§12 Dr. Stover opined that the July 22, 2011 accident did not cause a labral tear. Dr. Stover reviewed the medical records of Tyler Medical Services and Hinsdale Orthopaedics and noted the left hip MR arthrogram results. Dr. Stover noted Petitioner did not complain of specific hip joint type complaints following the July 22, 2011 accident. Dr. Stover opined that as a result of the July 22, 2011 accident, Petitioner sustained a contusion to the anterior aspect of his thigh and lateral aspect of his left hip. Dr. Stover opined that it is more probable that Petitioner slowly developed over time a degenerative labral tear secondary to his femoral morphology and this became symptomatic. Dr. Stover opined that the July 22, 2011 accident did not render Petitioner's left hip symptomatic and did not cause a labral tear or his femoral morphology. The Commission finds the opinions of Dr. Stover more persuasive than those of Dr. Domb. Dr. Stover's opinions reflect the actual events that occurred in this case. All other issues are moot.

15IWCC0030

IT IS THEREFORE ORDERED BY THE COMMISSION that since Petitioner failed to prove that a causal relationship exists, his claim for compensation and medical expenses is hereby denied.

There is no bond as there is no award. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JAN 1 5 2015
MB/maw
o12/04/14
43

Mario Basurto

Stephen J. Mathis

David L. Gore

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

Spencer Hansen,

Petitioner,

vs.

NO: 08 WC 24790

15IWCC0031

Lakeside Transportation,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical expenses, 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 June 5, 2013, 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.

15IWCC0031

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $47,300.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JAN 15 2015
TJT:yl
o 11/18/14
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HANSEN, SPENCER D
Employee/Petitioner

Case# **08WC024790**

LAKESIDE TRANSPORTATION
Employer/Respondent

15IWCC0031

On 6/5/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

2089 BUDIN LAW OFFICES
JOHN J BUDIN
1 N LASALLE ST SUITE 2165
CHICAGO, IL 60602

0208 GALLIANNI DOELL & COZZI LTD
ROBERT J COZZI
20 N CLARK ST SUITE 1800
CHICAGO, IL 60602

15IWCC0031

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

Spencer D. Hansen,
Employee/Petitioner

v.

Lakeside Transportation,
Employer/Respondent

Case # **08** WC **24790**

Consolidated cases: **none**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Peter M. O'Malley**, Arbitrator of the Commission, in the city of **Chicago**, on **2/26/13**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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 _____

15IWCC0031

FINDINGS

On **4/28/08**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$20,919.60**; the average weekly wage was **$402.30**.

On the date of accident, Petitioner was **66** years of age, ***single*** with **no** dependent children.

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

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

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

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $268.20 per week for 14 weeks, commencing 4/30/08 through 8/5/08, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from 4/29/08 through 2/26/13, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $384.95 to NorthShore University HealthSystem and $24,971.60 to Evanston Northwestern Healthcare, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $241.38 per week for 75 weeks, because the injuries sustained caused the 15% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

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

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

Signature of Arbitrator

5/22/13
Date

JUN - 5 2013

STATEMENT OF FACTS:

Petitioner, a 66 year old school bus driver, testified that he would typically work two different shifts on the same day; morning shift from approximately 6:00 a.m. until 9:30 a.m. and then from 1:00 p.m. until 5:00 p.m. Petitioner testified that after serving four years in the Marines, he obtained his college degree and then was employed for 30 years with the United States Department of Labor as a project manager in Job Corp programs until his retirement in 2004. He started his employment with Respondent in August, 2007.

Petitioner acknowledged a prior incident of low back pain approximately one year before the alleged accident in question. He noted that he only required some over-the-counter pain relievers following this incident and felt better. Thereafter, he returned to his daily activities without restrictions and was working full duty at the time of the injury. He also noted that he was not taking any pain medication and was feeling fine during the period leading up to the alleged incident.

Petitioner testified that at approximately 4:00 pm on April 28, 2008 he had finished his afternoon route and had pulled off to inspect his bus for any students or anything else left behind when he placed his foot down to reach for the student door and felt a twinge in his back. He noted that he completed his inspection following the incident, walking to the back of the bus and opening and closing the escape door. He indicated that when he walked to the front of the bus he felt pain in his right leg. Petitioner testified that he had never felt that kind of pain before.

Petitioner indicated that he returned to work the following day and drove his morning route. He noted that afterwards he walked extremely slowly back to the office to drop off the key. Petitioner testified that he then told his supervisor, Peggy Sue Passe, that he had injured his back driving the bus and that she just turned around and walked away.

Petitioner indicated that he then called Dr. Revis and was told he was not available. Instead, Petitioner made an appointment to see Dr. Sharon Doss the following day. In a progress note dated April 30, 2008, Dr. Doss recorded a history of "… back pain for the past 3 days. Developed pain while driving a school bus 3 days ago. Initially felt as a 'twinge' and progressively worsened through the day. Pain now constant, 7-8/10 in intensity, radiates down the Rt buttock and RLE. No muscle weakness. Gait unsteady due to pain. Tried Ibuprofen with no significant relief. Similar pain a year ago which responded to Ibuprofen. No trauma that he can recall prior [to] either episode." (PX8). Upon examination, Dr. Doss noted positive findings, including marked limitation in flexion, paraspinal spasm and tenderness to palpation at L5-S1. (PX8). Dr. Doss also noted that Petitioner was unable to do a straight leg raising test due to an inability to lie supine on the exam table secondary to pain. (PX8). X-rays of the lumbar spine taken at that time revealed degenerative change with narrowing of the L5-S1 disc space as well as sclerosis and narrowing of the posterior apophyseal joints. (PX1). Dr. Doss' assessment was back pain with "[n]o precipitating trauma." (PX8). Dr. Doss prescribed Darvocet, Flexeril and a Medrol dose pack. (PX8). Dr. Doss also indicated that Petitioner would be taking time off and that if he had no improvement he may need further evaluation and work up. (PX8). Petitioner testified that he was also told to see a neurologist.

On May 12, 2008 Petitioner underwent an MRI of the lumbar spine which was interpreted as revealing a prominent right paramedian and subarticular disc herniation at L4-L5 with caudal migration and imaging evidence of impingement on the right L5 nerve root. (PX4).

A subsequent addendum MRI report, dated May 28, 2008, noted an additional finding of a posterior left renal mass upon further review. (PX5). X-rays on June 4, 2008 later revealed a complex hypoechoic lesion in the lower pole of the left kidney. (PX1). This condition is not work related and is not part of the current claim.

On May 19, 2008, Petitioner visited Dr. Joseph Alleva at which time it was noted that Mr. Hansen presented "… with a chief complaint of low back pain that radiate[s] down the right leg in the region of L4-5. It has been going on for several weeks with no event…" (PX10). Following his examination and review of the MRI, Dr. Alleva presented Petitioner with various options, including medication, epidural steroid injections, physical therapy and possible surgery, although it was noted that Mr. Hansen was not a candidate for the latter at that time. (PX10). Petitioner chose the epidural steroid injection route, and advised Petitioner to avoid repetitive bending and twisting as well as heavy lifting and prolonged static postures. (PX10).

On May 20, 2008 Petitioner received an epidural injection. (PX1). Petitioner testified that the shot relieved a lot of the pressure but did not do anything about his right foot.

In an office note dated May 29, 2008, Dr. Alleva noted that Petitioner reported modest improvement/change in his symptoms following the injection. (PX1). Dr. Alleva recommended that Petitioner remain on "some home program" and "will follow up with the neurosurgeon given the pain. In retrospect he thinks driving the bus may have precipitated the pain." (PX1).

Petitioner eventually visited neurosurgeon Dr. Egon Doppenberg. In a progress note dated June 10, 2008, Dr. Doppenberg recorded that Petitioner "… got injured at the job while he worked as a bus driver. He started with leg pain from the knee into the top of the foot. This started April 30, 2008 after he was trying to open the door at work. He could not stand up at that time due to the pain…" (PX1). Dr. Doppenberg noted that the lumbar MRI had revealed an extruded disk herniation on the right at L4-5 causing compression on the L5 nerve root, which he noted was "… consistent with the patient's symptoms." (PX1). Dr. Doppenberg's recommendation at that time was surgical intervention in the form of an L4-5 minimally-invasive microdiskectomy. (PX1).

Petitioner testified that he subsequently underwent surgery in July of 2008. Petitioner testified that two days after surgery he felt great and that his leg pain and everything went away.

In a report dated August 5, 2008, Dr. Doppenberg noted that Petitioner's lumbar problem "… started all after an incident at work as a school bus driver. Initially, it bothered him while he was opening up the door of the bus, and later on while getting up out of the chair he immediately felt pain radiating down the leg." (PX11). Dr. Doppenberg indicated that Petitioner "… has recovered nicely from his surgery and he will contact me with his progress." (PX11). Petitioner testified that this was the last time he visited D. Doppenberg. Petitioner claimed that Dr. Doppenberg advised him not to drive a school bus, given that the injury might reoccur.

In a letter to Petitioner's counsel dated October 13, 2008, Dr. Doppenberg once again recorded a history of being "… injured on the job while at work as a bus driver. He noted that it started off as back pain while reaching for the door opener and than (sic) progressively got worse and turned into right leg pain in the middle of the day, he had difficulty getting up out of the chair. Prior to this incident he never had trouble with back pain or leg pain. The date of this injury was April 30, 2008…" (PX12). Dr. Doppenberg also noted that "[a]s far as I can tell he was unable to work since the date of the injury up until I saw him at the clinic. At that time, I explained to him that he could return to work as a bus driver if he wished to do so. I do not feel that he has any restrictions at this point as far as activities are concerned. However, any time a patient has a herniated disc they have a higher chance of developing down the line further disc degeneration in resulting either in back pain or reoccurrence disc herniation. I feel that more likely than not the patient's disc herniation and subsequent

symptoms were related due to the injury at work. He is very clear in describing the presence of pain that persisted while the injury happened. Also, the MRI shows a clear cut unequivocal large disc herniation at L4-5 compressing on the L5 root that was very consistent with the patient symptoms. Again, more likely that (sic) not I feel that this is related [to] the injury he sustained… As far as his prognosis is concerned, it should be excellent …" (PX12). Dr. Doppenberg essentially expressed the same opinion during his evidence deposition on July 8, 2011. (PX13).

Petitioner testified that he returned to Respondent in early May of 2009 to pick up a check. He indicated that he saw Ms. Passe at that time and was told that she had to fire him due to his injury. Petitioner stated that he never asked for an unpaid leave of absence and never returned to work for Respondent thereafter. Petitioner testified that he currently feels fine "for a 71 year old" and felt that the surgery had "cured" him.

Operations manager Peggy Sue Passe testified that she was the manager on the date of the alleged accident. She noted that pursuant to Respondent's employee handbook (RX2) injuries are to be reported immediately. Ms. Passe denied Petitioner reported an injury to her on April 28, 2008 and that she turned and walked away. Ms. Passe indicated that she would have taken down the information then faxed it to the risk manager, after which she would have made sure the employee got to a doctor to get the attention they needed. She also testified that Petitioner was a good worker, as far as she knows, was working full duty with no restrictions at the time of the alleged accident and that he had not voiced any prior complaints of low back pain. Ms. Passe indicated that Petitioner did request a leave of absence but that he did not qualify for FMLA. Instead, Ms. Passe noted that she approved a medical leave of absence for Petitioner on May 16, 2008. (RX3). Ms. Passe stated that she was the one to fill out the paperwork in this regard and that Petitioner had signed it. Ms. Passe testified that Petitioner never told her that he had injured himself at work. She also indicated that she did not ask Petitioner about his back at that time or how he had injured it. Furthermore, Ms. Passe stated that she never told Petitioner that he was fired, but that he never returned from his leave of absence and requested work. Finally, Ms. Passe indicated that she had driven the large school bus herself, specifically in 2008, and that she was familiar with the door handles. She testified that one does not have to lean forward and twist or move one's back in order to open the door. Instead, she indicated that one would have to reach out and cock the wrist a little to do so. She did agree, however, that drivers are required to wear seatbelts. Ms. Passe also noted that she reviewed the maintenance records for the bus Petitioner was assigned to, #358, and did not see any complaints from any drivers as to any problem with the door mechanism.

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

Petitioner testified that at approximately 4:00 pm on the date in question he had finished his afternoon route and had pulled off to inspect his bus for any students or anything else left behind when he placed his foot down to reach for the student door and felt a twinge in his back. He noted that he completed his inspection following the incident, walking to the back of the bus and opening and closing the escape door. He indicated that when he walked to the front of the bus he felt pain in his right leg. Petitioner testified that he had never felt that kind of pain before. He did note, however, that he had visited Dr. Revis one time for his back a year earlier, but that he had not seen any other doctors thereafter until after the incident on April 28, 2008. Petitioner also testified that he was working full duty without any restrictions and was feeling fine, without the need for any pain medication, during the period leading up to the date of the alleged injury.

Petitioner indicated that following the incident he drove back to the yard, secured his bus and went and dropped off the key. He noted that that was when he really started feeling pain in the back of his leg down to his foot.

He stated that he went home and returned the following day to perform his morning route. He noted that when he finished his route he walked extremely slowly back to the office to drop off the key when he encountered his supervisor, Petty Sue Passe. Petitioner testified that he informed Ms. Passe at that time that he had hurt his back driving the bus, and that Ms. Passe turned around and walked away.

Ms. Passe denied that Petitioner reported an injury to her on April 28, 2008 and that she turned and walked away. She also agreed that Petitioner was a good worker, as far as she knew, was working full duty with no restrictions at the time of the alleged accident and that he had not voiced any prior complaints of low back pain. In addition, Ms. Passe testified that having driven the large school bus herself she was of the opinion that one does not have to lean forward and twist or move one's back in order to open the door. Instead, she indicated that one would have to reach out and cock the wrist a little to do so. Ms. Passe also noted that she reviewed the maintenance records for the bus Petitioner was assigned to, #358, and did not see any complaints from any drivers as to any problem with the door mechanism.

Petitioner indicated that following his encounter with Ms. Passe he called Dr. Revis and was told he was not available. Instead, Petitioner made an appointment to see Dr. Sharon Doss the following day. In a progress note dated April 30, 2008, Dr. Doss recorded a history of "… back pain for the past 3 days. ***Developed pain while driving a school bus 3 days ago. Initially felt as a 'twinge' and progressively worsened through the day.*** Pain now constant, 7-8/10 in intensity, radiates down the Rt buttock and RLE. No muscle weakness. Gait unsteady due to pain. Tried Ibuprofen with no significant relief. Similar pain a year ago which responded to Ibuprofen. No trauma that he can recall prior [to] either episode." (Emphasis added). (PX8). Dr. Doss' assessment was back pain with "***[n]o precipitating trauma.***" (Emphasis added) (PX8).

Petitioner eventually visited Dr. Joseph Alleva at which time it was noted that Mr. Hansen presented "… with a chief complaint of low back pain that radiate[s] down the right leg in the region of L4-5. ***It has been going on for several weeks with no event…***" (Emphasis added) (PX10). However, in a subsequent note dated May 29, 2008, Dr. Alleva recorded that "… ***[i]n retrospect he thinks driving the bus may have precipitated the pain.***" (Emphasis added). (PX1).

Petitioner eventually visited neurosurgeon Dr. Egon Doppenberg. In a progress note dated June 10, 2008, Dr. Doppenberg recorded that Petitioner "… ***got injured at the job while he worked as a bus driver.*** He started with leg pain from the knee into the top of the foot. ***This started April 30, 2008 after he was trying to open the door at work.*** He could not stand up at that time due to the pain…" (Emphasis noted) (PX1).

Later, in a report dated August 5, 2008, Dr. Doppenberg noted that Petitioner's lumbar problem "… ***started all after an incident at work as a school bus driver. Initially, it bothered him while he was opening up the door of the bus, and later on while getting up out of the chair he immediately felt pain radiating down the leg.***" (Emphasis added). (PX11).

The above evidence shows that Petitioner was not actively treating for any low back condition and was working full duty without the need for pain medications during the period leading up to the alleged date of accident. It would also appear that despite a few inconsistencies in the histories, the preponderance of the evidence supports Petitioner's claim that he experienced an acute onset of symptoms while at work on April 28, 2008, including pain into his right leg and foot, something he had not experienced a year earlier when he had an instance of lower back pain which he had been able to treat with over-the-counter pain medication. These records, in conjunction with Petitioner's credible testimony, show that Petitioner initially felt this pain when he reached to open the door of his bus, and that the symptoms subsequently increased when he got up and walked to the back of the bus and back. The aforementioned medical histories are not so much diametrically opposed to

Petitioner's testimony at arbitration as they are incomplete, the by-product of not only a patient possibly unsure as to the exact cause of his complaints as well as lay persons more interested in recording a history from a medical perspective and not necessarily from a legal standpoint. The ensuing confusion is no better illustrated than by the seemingly incongruous statement by Dr. Doss, in her initial office note, that Petitioner had initially experienced a twinge while driving a school bus 3 days prior, which had progressively worsened through the day, to her subsequent reference to "[n]o precipitating trauma." (PX8). Likewise, while Dr. Alleva's initial progress note refers to the fact that Petitioner's complaints have "...been going on for several weeks with no event...," he later felt the need to amend his history to show that "... [i]n retrospect [Petitioner] thinks driving the bus may have precipitated the pain." (PX1). Eventually, Petitioner visited Dr. Doppenberg who recorded an even more detailed history of injury, although he references the wrong date, wherein Mr. Hansen injured himself while working as a bus driver, noting that "... [i]nitially, it bothered him while he was opening up the door of the bus, and later on while getting up out of the chair he immediately felt pain radiating down the leg." (PX11). Taken as a whole, the Arbitrator therefore finds that it is more likely than not that the onset of symptoms were precipitated by the incident at work, as described by Petitioner.

As far as the discrepancy between Mr. Hansen's and Ms. Passe's versions of events is concerned, it would seem to go more to the question of whether or not the former informed the latter of his injury when he claims he did. And since there is no dispute as to notice (See Arb.Ex.#1), given that the Application for Adjustment of Claim was filed within 45 days of the accident (on 6/4/08), the issue is moot.

Therefore, based on the above, and the record taken as a whole, including Petitioner's credible testimony as to the onset of his lower back pain on the date in question, the Arbitrator finds that Petitioner proved by a preponderance of the credible evidence that he sustained accidental injuries arising out of and in the course of his employment on April 28, 2008.

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

Petitioner testified that except for an instance of low back pain approximately a year earlier, which he had been able to successfully treat using over-the-counter pain medication, he had never suffered from low back pain and never experienced any type of pain shooting down his leg such as he experienced on April 28, 2008. Indeed, the record shows that Petitioner was working full duty at the time of the incident and was not actively treating or under any restrictions with respect to his low back. Along these lines, Petitioner's supervisor, Ms. Passe, agreed that Petitioner had not made any prior complaints relative to his lower back and was working full duty with no restrictions during the period leading up to the accident on April 28, 2008.

Board certified neurosurgeon Dr. Doppenberg testified that he first examined Petitioner on June 10, 2008 at which time he recorded a history of the injury and the onset of right leg pain into the foot "... after trying to open the door of his bus while at work." (PX13, p.7). Dr. Doppenberg went on to opine that "... considering the patient's history, together with the imaging findings [evidencing a large right-sided extruded disc at L4-5] and the patient's physical exam, that more likely than not his symptoms of pain and weakness were related to the accident – incident happening in the bus." (PX13, p.8). On cross examination, Dr. Doppenberg noted that his recollection was that Petitioner had "... reached over to either force open the door manually or close the door manually, reaching over to this right side where the door was..." and that "[a]ny torque movement or twist in the low back can result in a disc herniation." (PX13, pp.15-16).

At the request of Respondent, Petitioner was examined by board certified orthopedic surgeon Dr. Michael Kornblatt on December 3, 2008. (RX5, p.6). Dr. Kornblatt recorded a history of Petitioner reaching to open the

door with his right hand on April 28, 2008 when he "noted a twinge of pain in his neck" followed by "sharp right leg pain, pain in the right buttock radiating down his whole leg" after finishing his route and stepping off his seat to walk about the bus. (RX5, p.7). Following his exam and review of the records, Dr. Kornblatt opined that "... the cause of the herniated disc was degenerative in nature... [and] that reaching with his upper extremity while in a seated position would cause a clinical herniated disc, and [he] also did not feel that arising from a seated position and walking would result in a clinical herniated disc." (RX5, pp.15-16). Instead, Dr. Kornblatt felt that the cause of the herniated disc was "[a] degenerative condition of the lumbar spine, degenerative disc disease." (RX5, p.16).

Based on the above, and the record taken as a whole, the Arbitrator finds that a causal relationship exists between Petitioner's current condition of ill-being with respect to his lower back and the accident on April 28, 2008. Along these lines, the Arbitrator finds the opinions of treating surgeon Dr. Doppenberg to be more persuasive than those offered by Respondent's §12 examining physician, Dr. Kornblatt, particularly in light of the Arbitrator's finding with respect to accident (issue "C", supra) and the fact that Petitioner was working full duty without restrictions and without the need for pain medication on the date of the incident in question.

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 submitted into evidence an agreed stipulation setting forth the amount of medical expenses that would be due and owing pursuant to the fee schedule in the event this matter was found to be compensable, with Respondent maintaining any objection it may have as to liability and/or reasonableness and necessity. (Arb.Ex.#2).

Based on this stipulation, and in light of the Arbitrator's determination as to accident and causation (issues "C" and "F", supra), the Arbitrator finds that Petitioner is entitled to the following reasonable and necessary medical expenses pursuant to §8(a) and the fee schedule provisions of §8.2 of the Act: NorthShore University HealthSystem in the amount of $384.95 and Evanston Northwestern Healthcare in the amount of $24,971.60.

WITH RESPECT TO ISSUE (K), WHAT AMOUNT OF COMPENSATION IS DUE FOR TEMPORARY TOTAL DISABILITY, THE ARBITRATOR FINDS AS FOLLOWS:

Following the injury, Petitioner visited Dr. Doss on April 30, 2008. On that date Dr. Doss prescribed medication, noted that Petitioner would be taking time off and that if he had no improvement he might need further evaluation and work up. (PX8). Petitioner testified that he was also told to see a neurologist.

Petitioner remained off work and was eventually released to return to work by treating neurosurgeon Dr. Doppenberg on August 5, 2008.

Therefore, based on the above, and the record taken as a whole, including the Arbitrator's determination as to accident and causation (issues "C" and "F", supra), the Arbitrator finds that Petitioner was entitled to temporary totally disability benefits from April 30, 2008 through August 5, 2008, for a period of 14 weeks.

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

On May 12, 2008 Petitioner underwent an MRI of the lumbar spine which was interpreted as revealing a prominent right paramedian and subarticular disc herniation at L4-L5 with caudal migration and imaging evidence of impingement on the right L5 nerve root. (PX4).

Petitioner eventually underwent a L4-L5 microdiscectomy at Evanston Hospital on July 14, 2008. The surgery was a success. Dr. Doppenberg saw Petitioner three weeks later and discharged him on August 5, 2008. At that time, Petitioner stated that his right lower extremity pain and low back pain were much improved. Petitioner testified that he currently feels fine "for a 71 year old" and felt that the surgery had "cured" him.

Based on the above, and the record taken as a whole, the Arbitrator finds that as a result of accidental injures arising out of and in the course of his employment on April 28, 2008 Petitioner suffered permanent partial disability to the extent of 15% person-as-a-whole pursuant to §8(d)2 of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Thomas Wade,

Petitioner,

vs. NO: 06 WC 43861

15IWCC0032

Foster Electric Company,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 10, 2013, 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.

15IWCC0032

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $6,300.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JAN 1 6 2015
TJT:yl
o 1/6/15
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WADE, THOMAS
Employee/Petitioner

Case# **06WC043861**

FOSTER ELECTRICC
Employer/Respondent

15IWCC0032

On 7/10/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.07% 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:

1315 DWORKIN & MACICAIELLO
JOHN S ELIASIK
134 N LASALLE ST SUITE 1315
CHICAGO, IL 60602

4412 ACCIDENT FUND HOLDINGS INC
GRACE DiGERLANDO
200 W MADISON ST SUITE 3850
CHICAGO, IL 60606-3465

15IWCC0032

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

Thomas Wade
Employee/Petitioner

v.

Foster Electric
Employer/Respondent

Case # **06** WC **43861**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Barbara N. Flores**, Arbitrator of the Commission, in the city of **Chicago**, on **May 9, 2013 and May 16, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **September 7, 2006**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$61,976.72**; the average weekly wage was **$1,191.86**.

On the date of accident, Petitioner was **39** years of age, ***married*** with **3** dependent children.

Petitioner ***has*** received all reasonable and necessary medical services as explained *infra*.

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

Respondent shall be given a credit of **$N/A** for TTD, **$N/A** for TPD, **$N/A** for maintenance, and **$N/A** for other benefits, for a total credit of **$N/A**. *See* AX1.

Respondent is entitled to a credit of **$0** under Section 8(j) of the Act. *See* AX1.

ORDER

As explained in the Arbitration Decision Addendum, the Arbitrator finds that Petitioner failed to establish causal connection between his claimed current condition of ill being and his injury at work on September 7, 2006, that Respondent is liable for any additional unpaid medical bills, or that he is entitled to any prospective medical care as it relates to his injury at work. The Arbitrator further finds the following related to the nature and extent of Petitioner's injury at work:

Respondent shall pay Petitioner permanent partial disability benefits of $619.97/week for 10 weeks, because the injuries sustained caused 2% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

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

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

Signature of Arbitrator

July 10, 2013
Date

JUL 10 2013

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION *ADDENDUM*

Thomas Wade
Employee/Petitioner

v.

Foster Electric
Employer/Respondent

Case # **06** WC **43861**

Consolidated cases: **N/A**

FINDINGS OF FACT

Petitioner's cause came to arbitration previously. The parties proceeded to trial on April 6, 2011 before Arbitrator Carlson pursuant to Petitioner's Section 19(b) petition. Petitioner submitted a copy of the transcript from that hearing into evidence. Petitioner's Exhibit ("PX") 16. Subsequent to the hearing, Arbitrator Carlson issued findings of fact and conclusions of law. Respondent's Exhibit ("RX") 13.

Arbitrator Carlson found that the Petitioner's condition of ill being was not related to his accident of September 7, 2006, that the Respondent had paid all reasonable medical, and that temporary total disability benefits were not due and owing beyond November 5, 2010. RX13. Arbitrator Carlson also found that Respondent was not liable for the payment of medical bills beyond October 6, 2010 and that Petitioner was not entitled to prospective medical care. *Id.* Arbitrator Carlson further found that Petitioner sustained a non-displaced nasal bone fracture as a result of his injury of April 6, 2011 and specifically found "no causal connection for any other claimed medical conditions." *Id.*

No Commission or reviewing court's decision was issued pursuant to any petition for review or appeal thereafter. The Arbitrator hereby adopts and incorporates by reference the findings and conclusions made by Arbitrator Carlson in his Corrected 19(b) Decision dated June 20, 2011.

On May 9, 2013, Petitioner testified before this Arbitrator in support of his position on the following disputed issues: causal connection, Respondent's liability for certain unpaid medical bills, the nature and extent of Petitioner's injury, and Petitioner's entitlement to prospective medical treatment. Arbitrator's Exhibit ("AX") 1; May 9, 2013 Arbitration Hearing Transcript.

Continued Medical Treatment

Petitioner testified that since the last trial, he continues to see Dr. Michael Epstein in Arizona and sees him every six months during which he has prescribed various medications that Petitioner continues to take.

Dr. Epstein's medical records reflect that he saw Petitioner on November 29, 2011. PX17 at 2-4. Dr. Epstein noted that Petitioner returned with "no real change in his condition." *Id.* Petitioner claimed "to be more mellow and accepting it better, but he has gained a great deal of weight" and was not exercising. *Id.* He also reported that he only walked a little ways before he got a headache, he still had "temper outburst[s]" and Dr. Epstein discussed the need to control this. *Id.* Dr. Epstein also noted that Petitioner's injury was now several years ago "and the current reality needs to take hold, he cannot sit around thinking of what he wishes would happen." *Id.*

Dr. Epstein examined Petitioner and noted that the results were "good." *Id.* Dr. Epstein's impression was that Petitioner had "reached a stationary state. He rues not being able to work. His coworkers from his job has made a lot of money in Iraq and Afghanistan and he is has [sic] done nothing, but these are not issues easily dealt with. There is not going to be a lot of change." *Id.* Dr. Epstein noted that Petitioner continued to take Norco,

Depakote and Valium. *Id.* He also noted that no changes were planned, Petitioner needed to work to make adjustments to his current, chronic state of affairs which he had no particular reason to think would change anytime soon, and diagnosed Petitioner with post-concussion syndrome with headaches. *Id.*

Petitioner followed up with Dr. Epstein approximately one year later on August 27, 2012. PX17 at 5-7. He maintained his diagnosis of postconcussion syndrome, refilled Petitioner's medications including Norco and Valium, and instructed him to return in six months worth his symptoms worsened were persisted. *Id.*

Petitioner acknowledged that his complaints to Dr. Epstein have been the same, including headaches and dizziness, since the date of injury. Petitioner acknowledged that he is currently taking Norco, Depakote, Anatripoline, and Valium, which he has been taking throughout his treatment with Dr. Epstein. Petitioner further acknowledged that nothing new has occurred from the date of injury through the date of trial and that his headaches and dizziness have remained the same.

Additional Information

Before his accident, Petitioner enjoyed being around people, being outdoors, being with people, working, and fishing. Regarding his current condition in daily life, Petitioner testified that he cannot go back to work or work for the IBEW. He cannot play with his kids anymore, he is too aggressive and becomes aggressive quickly, and he is not the same. He has medication to calm down, but he hollers at his kids and does not like being around anyone. He also testified that everyone tells him that he does not know what he is talking about, people make fun of him, and that everyone is against him right now. He still gets headaches and takes headache medication which calms him down a little bit. He testified that his headaches are at a pain level of 7-8/10 before his medication, but the medications resolve his headaches. Petitioner testified that he still gets dizzy if he starts doing things that he should not do, like getting something out of the dryer, doing housework, or bending over. Petitioner currently receives social security disability benefits.

ISSUES AND CONCLUSIONS

The Arbitrator hereby incorporates by reference the Findings of Fact delineated above and the Arbitrator's and parties' exhibits (AX1, PX16-PX17, and RX13) are made a part of the Commission's file. After reviewing the evidence and due deliberation, the Arbitrator finds on the issues presented at trial as follows:

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

The Arbitrator finds that Petitioner's claimed current condition of ill being is not causally related to his injury at work on September 7, 2006. In so finding, the Arbitrator notes that on June 21, 2011, Arbitrator Carlson found that Petitioner's condition of ill being was not causally related to his injury of September 7, 2006 through the April 6, 2011 hearing date. "The rule of the law of the case is a rule of practice, based upon sound policy that, where an issue is once litigated and decided, that should be the end of the matter and the unreversed decision of a question of law or fact made during the course of litigation settles that question for all subsequent stages of the suit." *McDonald's Corp. v. Vittorio Ricci Chicago, Inc.*, 125 Ill.App.3d 1083, 1086-1087, 91 Ill.Dec. 314 (Ill. App. Ct., 1984). The Appellate Court went on to state that the "trial court order becomes the 'law of the case' only if there is a final and appealable order." *Id.*, (citation omitted).

At the section 19(b) stage, Arbitrator Carlson found that a causal connection existed between Petitioner's right nasal bone fracture and his injury of September 7, 2006 only; he found no causal connection between any of

Petitioner's other claimed medical conditions (i.e., post-concussion syndrome with symptoms of blurred vision, headaches, memory loss, mood swings, and dizziness) and his injury on September 7, 2006. Arbitrator Carlson's decision became a final judgment from which Petitioner did not appeal. Thus, the findings of fact and conclusions of law determined by Arbitrator Carlson became the law of this case.

Notwithstanding, in consideration of Petitioner's updated medical records from Dr. Epstein and after hearing Petitioner's testimony, the Arbitrator finds that Petitioner's alleged current condition of ill being is no different than his condition of ill being at the time of his 19(b) hearing in April of 2011. Petitioner has failed to establish through credible or persuasive evidence that his post-concussion syndrome condition is now causally related to his injury on September 7, 2006. Based on all of the foregoing, the Arbitrator finds that Petitioner's claimed current condition of ill being is not causally related to his injury at work on September 7, 2006.

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:

As explained above, the Arbitrator adopts and incorporates Arbitrator Carlson's Corrected Decision dated June 21, 2011 and finds that Petitioner failed to establish through credible or persuasive evidence that his post-concussion syndrome condition is now causally related to his injury on September 7, 2006. Thus, the Arbitrator finds that Petitioner has failed to establish that the medical services rendered after April 6, 2011 were reasonable and necessary to treat any causally related condition and that Respondent has paid all appropriate charges for all reasonable and necessary medical services. Thus, Petitioner's claim for payment of any outstanding medical bills submitted into evidence 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:

Based on the record as a whole, and as explained in detail above, the Arbitrator adopts and incorporates Arbitrator Carlson's Corrected Decision dated June 21, 2011 and finds that Petitioner failed to establish through credible or persuasive evidence that his post-concussion syndrome condition is now causally related to his injury on September 7, 2006. Arbitrator Carlson previously found that Petitioner's right nasal bone fracture was causally connected to his work related injury of September 7, 2006 and he found no causal connection between any of Petitioner's other claimed medical conditions and his injury at work. Arbitrator Carlson's Decision was not appealed and, thus, has become the law of the case. Based on the foregoing and the record as a whole, which reflects that Petitioner suffered from a right nasal bone fracture as a result of his injury of September 7, 2006, the Arbitrator finds that Petitioner has established permanent partial disability to the extent of 2% loss of use of the person as a whole pursuant to Section 8(d)(2) of the Act.

In support of the Arbitrator's decision relating to Issue (O), Petitioner's entitlement to prospective medical care, the Arbitrator finds the following:

As explained above, given Arbitrator Carlson's Decision of June 21, 2011 which is the law of this case and Petitioner's failure to establish any causal connection between his claimed current condition of ill being and his work injury, his claim for prospective medical care is denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

DARTANYUN GRIGGS,

Petitioner,

15IWCC0033

vs.

NO: 13 WC 37506

BERKSHIRE REFRIGERATED,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causation, temporary total disability, and medical expenses both current and prospective, and being advised of the facts and law, changes the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

Petitioner was a temporary non-union employee of Respondent on the date of his injury. He was using a hand forklift and caught his leg between the forklift and the wall injuring his left leg. Petitioner testified he was directed to use the forklift by a supervisor prior to the accident. However, Respondent presented testimony that only union employees are allowed to operate forklifts and a prospective operator must show proficiency in operating the devise before he is allowed to use one. In addition, the loads moved by the forklifts are computerized and the operator must be familiar with the process even to move any load. Petitioner testified that there was not any proficiency evaluation prior to his accident and he was not familiar with any of Respondent's computer systems. The Arbitrator denied compensation finding that "Petitioner was actively engaging in horseplay at the time of his injury. He was operating a pallet jack/forklift, which was not part of his job duties and which he obviously did not have the skill and training to do. Petitioner's actions were of no benefit to" Respondent.

15IWCC0033

The Commission notes that *Webster's New World College Dictionary* defines "horseplay" as "rough, boisterous fun." *Dictionary.Com* defines "horseplay" as "rough or boisterous play or pranks." In the case now before Commission, we find that the term "horseplay" is not really appropriate. Nevertheless, the Commission agrees with the Arbitrator that Petitioner's operation of the pallet jack/forklift was not part of his work duties. Therefore, the accident and his subsequent injuries did not arise out of his employment. Therefore, the Commission affirms the Decision of the Arbitrator and denies compensation.

IT IS THEREFORE ORDERED BY THE COMMISSION Petitioner's claim for compensation is denied

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

DATED: JAN 20 2015

Ruth W. White

Daniel R. Donohoo

Charles J. DeVriendt

RWW/dw
O-12/17/14
46

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

15IWCC0033

GRIGGS, DARTANYUN
Employee/Petitioner

Case# **13WC037506**

ACCURATE PERSONNEL SERVICES AND BERKSHIRE REFRIGERATED WAREHOUSING LLC
Employer/Respondent

On 5/29/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% 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:

4128 RUBENS AND KRESS
ROBERT B PAWLOWSKI
134 N LASALLE ST SUITE 444
CHICAGO, IL 60602

0210 GANAN & SHAPIRO PC
AMY L TURNBAUGH
210 W ILLINOIS ST
CHICAGO, IL 60654

1452 CHASE & WERNER LTD
MICHAEL I FISHER
300 W ADAMS ST SUITE 330
CHICAGO, IL 60606

2097 GRANT & FANNING
DANIEL K SWANSON
10 S RIVERSIDE PLZ SUITE 1770
CHICAGO, IL 60606

D. Griggs v. Accurate, Etc., et al, 13 WC 37506

15IWCC0033

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)

Dartanyun Griggs
Employee/Petitioner

Case # **13WC 37506** _____

v.

Consolidated cases: _____

Accurate Personnel Services and Berkshire Refrigerated Warehousing, LLC
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Jeffrey Huebsch**, Arbitrator of the Commission, in the city of **Chicago**, on **3/13/14**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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 **proof of dependent for benefit rates**

FINDINGS

On the date of accident, **11/2/2013**, Respondents *were* operating under and subject to the provisions of the Act.

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

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 Respondents.

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

In the year preceding the injury, Petitioner earned **$409.34**; the average weekly wage was **$409.34**.

On the date of accident, Petitioner was **43** years of age, ***single*** with **1** dependent child.

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

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$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 AN EMPLOYER/EMPLOYEE RELATIONSHIP EXISTED BETWEEN HIM AND RESPONDENT, ACCURATE PERSONNEL SERVICES.

PETITIONER FAILED TO PROVE THAT HE SUSTAINED ACCIDENTAL INJURIES, ARISING OUT OF AND IN THE COURSE OF HIS EMPLOYMENT BY RESPONDENT, BERKSHIRE REFRIGERATED WAREHOUSING, LLC.

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

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

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

Signature of Arbitrator

May 29, 2014
Date

ICArbDec19(b)

MAY 29 2014

INTRODUCTION/PROCEDURAL BACKGROUND

This matter was tried as a Section 19(b)/8(a) proceeding by Petitioner against two Respondents, Accurate Personnel Services ("Accurate") and Berkshire Refrigerated Warehousing, LLC ("Berkshire").

The issues in dispute as to Accurate were: Employer/Employee; Causal Connection; Wages; Age, Marital Status and Dependents; Liability for Medical Expenses (Prospective and Incurred); and TTD. Accurate did not dispute that Petitioner sustained accidental injuries, arising out of and in the course of his employment. (Arb Ex. 2)

The issues in dispute as to Berkshire were: Employer/Employee; Causal Connection; Dependents (Berkshire claiming 1 dependent to 2 claimed by Petitioner); Liability for Medical Expenses (Prospective and Incurred). Berkshire stipulated to the claimed Average Weekly Wage of $409.38. (Arb Ex. 3)

STATEMENT OF FACTS

Dartanyun Griggs ("Petitioner") testified that he began working for Respondent, Berkshire Refrigerated Warehousing, LLC, on October 29, 2013 at some point in the evening. According to Petitioner, he received a call from a former co-employee who had worked with him on other jobs, Calvin Shields, on his cell phone. According to Petitioner, Calvin was working at Berkshire and a supervisor there named Jose had asked Calvin if he knew any other people who had signed up with a temporary agency, Accurate Personnel, and could come to work for Berkshire. According to Petitioner, Calvin handed his cell phone to Jose and Jose asked Petitioner if he had been hired and was on the payroll for Accurate. Petitioner claimed he was. According to Petitioner, Jose requested that he come out to Berkshire's location. Petitioner testified he appeared at Berkshire within the next hour. Petitioner met with Jose, signed a time card and was put to work as a meat packer.

Petitioner testified that his duties for Berkshire were that of a meat packer. He worked in the "boxing room" and would off load, pack, and weigh food products, then box and label them. He confirmed that all of this work was of a manual labor nature.

Petitioner testified that on November 2, 2013, he was by a freezer/container in Berkshire's warehouse. Petitioner testified that a supervisor named Oscar told him to take a pallet jack into the freezer to pick up a new combo containing pigs feet and ham hocks and bring it to the boxing room so that the employees could unload and begin packing from that next combo. Petitioner testified that he obtained a pallet jack from the dock area by the trucks. He had to turn the jack around to go into the freezer because of the way the pallet jack was facing when he went to retrieve it. Petitioner testified he attempted to get the combo to take into the boxing room where everyone was working. He stated that he tried to turn the pallet jack around while standing on the machine, trying to pull it back. He then testified that, at that point, the jack smashed into his left lower leg.

Petitioner stated that he felt immediate pain and a few minutes later Oscar came to inquire why he was in such pain. Petitioner testified that Oscar told him to go back to work and continue to pack meat. Petitioner could not do so and asked to go home. As he continued to complain of pain in his left lower leg, he was told that an ambulance needed to be called in order to make a report.

Petitioner testified that the Chicago Fire Department came and transported him to the Mercy Hospital emergency room on the same day. (PX 3, 6) Petitioner then confirmed his treatment at Mercy and later at US Health Works, which happens to be Accurate's company clinic. (PX 6, 7) He said that he was initially provided a splint and crutches with a CAM walking boot. He testified that the fracture in his left lower leg could not be casted because of a foot fungus problem.

Because a dispute arose thereafter as to whether Petitioner was an employee of Accurate, who utilized US Health Works where Petitioner was treating as its company clinic, he then received treatment for a period of time at Cook County/Stroger Hospital. (PX 8) Petitioner next was evaluated at Illinois Orthopedic Network for a second opinion and then began treating at ATI for physical therapy based on that physician's recommendations. (PX 4, 5)

A review of the medical records documents that Petitioner appeared at Mercy Hospital on November 2, 2013. Specifically, with respect to the history provided at that time, the Mercy Hospital records (in the triage section) state that Petitioner "fell off a picker" and sustained a laceration to his left lower leg. The "emergency documentation" section of the Mercy records at page 17 notes the history that Petitioner "accidently fell off a small forklift." X-rays were taken and Petitioner was diagnosed with an incomplete possible stress related fracture through the posterolateral cortex of the mid to distal third of the tibia. Petitioner was discharged with crutches, as no cast could be placed due to an unrelated foot fungus. (PX 6)

A review of the US Health Works records shows that Petitioner first appeared there on November 4, 2013 in follow up. The history he provided at that time was that Petitioner "was driving a pallet jack, left foot slipped as he was making a turn and tried to stop from hitting a wall by using his foot. Left leg caught between the wall and equipment." Petitioner was diagnosed with the incomplete fracture and was continued in a non-weight-bearing status with crutch walking only. Petitioner returned to US Health Works on November 5, 2013. Petitioner was the same and continued with the same status. He returned on November 8, 2013 in follow up. He was continued with non-weight-bearing status of the left leg using a CAM walker boot. He was provided medications as well. Petitioner returned on November 15th at Us Health Works. At that point, he was referred for an orthopedic evaluation to discuss casting of the fracture. At that point, the abrasion on the left shin had healed. He was continued with non-weight-bearing status. (PX 7)

Petitioner stated that because US Health Works would no longer treat him, he ended up at Cook County/Stroger Hospital thereafter. The Arbitrator notes this is somewhat inaccurate as Petitioner was at US Health Works for a follow up on November 15, 2013. (PX 7) However, a review of Petitioner's records from Cook County/Stroger begins with Petitioner's visit on November 13, 2013. (PX 8)

On November 13' 2013, Petitioner appeared complaining of pain and swelling with warmth on his lower left leg. He indicated that weight bearing was causing him pain and he was currently using crutches. X-rays again were taken. Petitioner was provided an option of wearing the CAM boot or a three way splint. He was told to follow up with the orthopedic clinic at that time. Petitioner then appeared on November 18, 2013 and the history he provided was that he "slipped off electric palate (sic) skid and struck his leg against the wall." Petitioner was advised to stay in the CAM boot in a non-weight-bearing status and to follow up in four weeks. (PX 8) Petitioner returned to Stroger on December 16, 2013 for follow up. He was also complaining of occasional pain in his right elbow. (PX 8) The Arbitrator notes that at no point during Petitioner's testimony was there any allegation of a right elbow injury as part of this claim. At that time, he was told to advance to weight bearing status and to follow up in four weeks. Petitioner last appeared at Stroger on January 13, 2014. He was again kept with the CAM walker boot and told to follow up in six weeks. (PX 8)

Petitioner testified he chose to then seek a second opinion at Illinois Orthopedics Network on January 16, 2014, with Dr. Murtaza. The Arbitrator notes a review of the medical records document that Petitioner provided a history to Dr. Murtaza of "driving vehicle into a freezer to unload the meat… foot slipped out of the vehicle as he was turning and, as he could not control the car, he hit a pack of meat and states his foot was still outside the car and was crushed." Dr. Murtaza noted that Petitioner walked with a cane at that time. There is also a notation in the Illinois Orthopedic records at that point in the history/intake documentation that Petitioner was "separated" and living with his parents. Dr. Murtaza recommended Petitioner continue off work and referred Petitioner specifically for an orthopedic evaluation. (PX 4)

Contained within the Illinois Orthopedic Network records is an evaluation on January 17, 2014 at Advanced Foot and Ankle Centers of Illinois with a podiatrist, Dr. Joel Anderson. A review of that record documents the history Petitioner provided at that visit was that "foot slipped off a pallet jack, crushed between the jack and a pallet of frozen food." Petitioner explained to Dr. Anderson that his job duties only included standing, walking, carrying, lifting, pushing and pulling. (PX 4) The Arbitrator notes there is nothing that Petitioner documented as part of his job duties that Petitioner was required to drive a forklift and/or pallet jack. The podiatrist recommended a bone stimulator at that time. (PX 4)

Petitioner then began physical therapy at ATI on January 30, 2014 and the Arbitrator notes that the records contain daily SOAP notes through March 4, 2014. A review of those records documents that by February 17, 2014, Petitioner was told to walk with weight bearing status and no longer use crutches. There is also a notation on February 17, 2014, that Petitioner was complaining that he moved over the previous weekend and was in a little more pain as he was going up and down multiple sets of stairs. (PX 4) Petitioner testified at trial he moved to a third-floor walk-up apartment. The last therapy note documents that Petitioner last saw his physician the day before on March 3rd and apparently released him to light duty work. (PX 5) That chart is not contained in any of the records submitted at trial. The last medical report is February 12, 2014, in follow up with the podiatrist, Dr. Anderson. Petitioner advised that physical therapy was helping. The doctor recommended that Petitioner begin and continue with weight bearing status at all times. Petitioner apparently was provided a bone stimulator at that point. (PX 4)

At the time of trial, Petitioner testified that he was in continued discomfort and that he could not do activities with his kids like before. He said that he could not run around and play with his kids and was not working and could not provide for his family, but just simply sat in his house. He said that cold weather hurts his leg and that he could not stand on it for long periods of time and could not perform too much walking.

Petitioner testified on direct examination that he had four dependent children. However, upon questioning, Petitioner admitted that Eric, the oldest child, was 24 years-old. A second child named Deandre was 22 years-old. His third child, Tyshanna, was currently 16, and a fourth child, Dartaniun Jr., was currently 13 or 14 years old as Petitioner could not remember accurately.

The Arbitrator notes the following in relationship to the testimony surrounding the third child, Tyshanna. Specifically, a copy of Tyshanna's birth certificate was admitted as Petitioner's Exhibit 2. A review of the birth certificate notes that the child's name does not have the Petitioner's last name. The birth certificate does not list Petitioner as the father of Tyshanna. The birth certificate does not list anyone as Tyshanna's father. (PX 2)

Petitioner testified that he was the natural father of Tyshanna, but he had no documentation to substantiate the same. He testified that he was not married to Tyshanna's mother at the time that Tyshanna was either conceived or born. Petitioner also admitted that he was not living with Tyshanna's mother at the time that Tyshanna was born. Petitioner testified that he was living with Tyshanna and Tyshanna's mother at the time of

accident. However, there is no documentation to substantiate that. Petitioner's medical records indicate that Petitioner was seperated and living with his parents in his parents' home. The records document that Petitioner's address at the time of accident was 3938 W. Arthington in Chicago. Petitioner testified at the time of trial that he lived at 5537 W. Washington, #316 in Chicago. The medical records document that Petitioner moved to this current address in mid February of 2014.

In regard to the dependent issue, on behalf of Petitioner, Shandra Jones testified as Tyshanna's mother. According to Ms. Jones, Tyshanna is the Petitioner's daughter. However, upon questioning on cross examination, Shandra admitted that she was not married to Petitioner, nor living with Petitioner at the time that Tyshanna was conceived and/or born. She had no documentation to substantiate that there was/is a legal basis that Petitioner has been deemed Tyshanna's father. She could provide no documentation in support of her testimony.

On behalf of Berkshire, Ian Grzywacz (hereinafter "Ian") testified. Ian testified that he is currently the Vice President for Berkshire. He has worked there for approximately twenty years and has been Vice President more than five years. He testified that his job duties are to oversee every aspect of the day to day operations of the business and he is in charge, under the President. He testified that Berkshire's business is a public refrigeration warehouse. Berksire stores refrigerated and frozen food.

Ian testified that the majority of Berkshire's employees are union employees for the positions of truck drivers, checkers and forklift operators. He testified that they have a very small percentage of non-union workers. Those positions are for office personnel only. Berkshire also employs temporary workers. Temporary workers are employed for non- union unskilled labor positions, such as the job which Petitioner was performing, that of a meat packer in the "boxing room". With respect to the job position of a meat packer, Ian testified that packers work in the boxing room. There are skids and boxes that are 48x48x48, big cardboard boxes, which are brought into the boxing room and dumped onto a table. He stated there are six packing stations for packers to stand at. One person stands at each location, pulling meat from the dumper table into a box for packing and then sending the boxes down the conveyer. Ian explained that the checkers and/or forklift operators, which are union employees only, are those trained to retrieve the big combo boxes which are brought in for meat packers to use. Ian testified specifically that the position of checker and/or forklift driver is a union job and that temporary workers do not perform any of the union job activities, as there are monetary penalties and repercussions if a non-union worker performs a union job. Ian testified that with the packers are required to wear a white frock over their clothing as well as a hairnet in the boxing room because it is considered a "clean" room. Ian testified that the checkers and/or forklift operators who retrieve frozen combos from the freezer to be then taken into the boxing room also wear frocks, but not hairnets. However, checkers/forklift drivers are not required to leave the frocks in the boxing room. It is only the packers working in the boxing room that must remove their white frock and hairnet and leave them in the clean room every time they exit, which includes leaving to use the restroom, eat lunch, or end their shifts.

Ian then further testified that a checker and/or forklift operator must be trained and proficient in using the computer scanning system which Respondent uses in order to obtain the correct combos from the freezer. Ian testified that the freezer itself is a 120,000 square foot room with one main aisle down the center. He stated that pallets with the combos are on both sides of the aisle, stacked multiple high and long. Ian testified that there is a training process for the checkers and forklift operators to learn the computer system and utilize the same in obtaining correct combos. They have to understand the numerical system in order to know where to go in the freezer room to obtain the proper combo pallet, scan it to ensure that they have the right combo and then transport it from the freezer into the boxing room.

More so, Ian testified that when he contemplates hiring a new union employee as a forklift driver and/or checker, each candidate must perform a demonstration of their capabilities of operating a forklift and/or pallet jack appropriately. When asked what the consequence was if a non-union employee operated a forklift and/or pallet jack, Ian testified that the non-union employee would be immediately removed from the premises.

As part of Ian's testimony, a video of the accident as it occurred was shown and is Respondent's Exhibit 1 entered into evidence at trial. Ian explained the video from the fist frame prior to the video starting. When the initial frame is viewed, the camera is looking down a hallway, with the loading dock and truck bays on the right hand side of the screen. The "boxing room" which is where Petitioner was working, is on the left side, about half way up in the screen shot. To the farthest left hand upper corner is the entryway/door into the freezer which is where Petitioner said he was going to obtain a combo from. Ian testified that at the farthest north portion of what is in the viewing of the screen shot is actually not a wall, but multiple stacked pallets of orange juice combos. It is not a wall but is simply pallets stacked on top of each other with spaces in between. Ian further testified that to the top right hand corner is a hallway which leads to more of the loading dock. (RX 1) With respect to other cameras in the building, Ian testified that in that hallway there is a camera which is over the area where Petitioner is ultimately seen at the beginning of the video. However, according to Ian, that camera would be facing the hallway from the opposite direction and is not capable of "capturing" what would be directly below it, which is where Petitioner was at the beginning of the video. Ian confirmed that there are multiple cameras all around the building including outside the building and there is notification that everyone may be on video at any time. According to Ian, the camera that captured the video of Petitioner's alleged injury is the only camera that could capture what happened in the area where Petitioner claims to have been injured.

The video is approximately three minutes long. A review of the video documents that as it starts, Petitioner is already on the pallet jack and the pallet jack is moving backward and forward as if Petitioner cannot seem to get the pallet jack moving in the right direction. Petitioner then goes out of screen for several seconds. When he ultimately returns into view, Petitioner is no longer riding on the pallet jack/forklift at all but is actually walking behind it which, according to Ian, is an inappropriate use of that pallet jack. Petitioner then walks behind the jack, maneuvering it into a left turn so that the front of the empty pallet jack is directly facing forward toward the surveillance camera. (RX 1) The pallet jack is completely empty and is not holding any product. Petitioner then gets behind the jack, with his back to the stacked combos of orange juice and simply backs the pallet jack directly into himself. Thus, the reason for the operator to stand on the pallet jack platform. There is nothing that confirms that Petitioner had gone into the freezer to obtain a combo. There is no product on the pallet jack. Petitioner's multiple differing statements on how the accident occurred are not confirmed by the video. He ran the jack into himself because he did not know how to operate it properly and did not know where to stand when the jack was moving. The Arbitrator notes that in conjunction with Ian's testimony and explanation of what was on the video, Petitioner had not even entered the freezer room. (RX 1) A further review of the video shows that Petitioner is wearing the white frock and hairnet which Ian stated is specifically forbidden for Petitioner to continue to wear upon leaving the boxing room. Ian further testified that there is absolutely no basis that anyone, especially a supervisor, would request or tell a temporary worker/meat packer to get on a pallet jack, go into the freezer, obtain a combo and bring in to the boxing room as Petitioner alleges. According to Ian, the Petitioner would have absolutely no idea how to use the computer scanning system to know which combo to obtain in the freezer room, as there are at least sixty combo pallets at any given time in the freezer room. According to Ian, the only reason for Petitioner being out of the boxing room and in that hallway would be if he were ending his shift, leaving for lunch or taking a restroom break. For these tasks, Petitioner would be required to remove the white frock and the hairnet and leave them in the boxing room.

On cross examination, Ian testified that it was possible for the supervisor, Oscar, to have told Petitioner to use the pallet jack as Petitioner claimed. This testimony was in the line of anything is possible, as opposed to confirming some likelihood that the event occurred as Petitioner claimed.

Ian's testimony was not rebutted. Jose, Calvin Shields and Oscar were not called as witnesses by any of the Parties.

On cross examination, Petitioner was specifically asked, assuming Oscar had told him to go get a combo of "pigs feet/ham hocks" as Petitioner alleged, to explain how the computer scanning system worked and how he knew which combo to go in the freezer and obtain. The Arbitrator notes that Petitioner had no idea and could not explain anything about the computer system Berkshire uses. Petitioner also admitted that within the five days before the injury he that worked for Berkshire, at no point was he ever asked to demonstrate his alleged ability or proficiency of operating a forklift and/or pallet jack. Petitioner also admitted that leading up to this point he had never been asked to do any job duty other than what would be considered the manual labor position of packaging meat in the boxing room.

CONCLUSIONS OF LAW

The Arbitrator adopts the above Findings of Fact in support of the following Conclusions of Law.

Separate Conclusions of Law as to Petitioner's claims against each Respondent are set forth below under the Heading bearing that Respondent's name.

I. Accurate Personnel Services

With respect to (B) Was there an employee-employer relationship? The Arbitrator finds the following:

Petitioner failed to prove that an employee-employer relationship existed between him and Respondent, Accurate, on the date of accident. Petitioner's testimony establishes that he went to work at Berkshire at the request of a Berkshire employee, Jose. There was no testimony of any contact with anyone from Accurate regarding the meat packer job at Berkshire. There was no contract of hire between Accurate and Petitioner regarding this job and there was no evidence of any control over Petitioner's actions by anyone at Accurate.

As there is no employee-employer relationship between Petitioner and Accurate, Petitioner's claim for compensation against Accurate is denied.

With respect to (C) Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?; (F) Causal Connection; (G) Wages; (J) and (K) Medical Expenses; (L) TTD; and (O) Dependency, the Arbitrator finds the following:

As the Arbitrator has found that there was no employee-employer relationship between Petitioner and Respondent, Accurate, the Arbitrator needs not decide the above issues.

II. Berkshire Refrigerated Warehousing, LLC

With respect to (B), Was there an employee-employer relationship?, The Arbitrator finds the following:

Petitioner's testimony establishes that there was an employee-employer relationship between him and Berkshire. Petitioner reported to Berkshire's facility at the request of its agent, Jose. Jose had Petitioner sign a timecard, gave Petitioner a frock and a hairnet and put petitioner to work as a meat packer in the boxing room. Berkshire's witness conceded that it was plausible that Petitioner came to work at Berkshire in this way. Berkshire stipulated to Petitioner's claimed average weekly wage. The timecard was admitted into evidence as Petitioner's Exhibit 9.

Based upon the above, the Arbitrator finds that the relationship between Petitioner and Respondent, Berkshire, was that of employee/employer.

With respect to (C), Whether an accident occurred that arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator finds the following:

It is well established in Illinois that an injured worker whose own injury is the result of "horseplay" is not able to recover workers' compensation benefits since the accident and/or injury did not arise out of the employment. Frank Farrley v. Famous Freddies, 07 IWCC 1361 (October 22, 2007) Under certain circumstances, an active participant in horseplay can recover benefits, only if they have "disengaged" from the horseplay activity prior to the accident. Craig v. Farm and Fleet , 09 IWCC 0217 (March 3, 2009), citing Harvard v. Chicago Park District , 05 IIC 0288 (April 11, 2005) Here, Petitioner was actively engaged in horseplay at the time of his injury. He was operating a pallet jack/forklift, which was not part of his job duties and which he obviously did not have the skill and training to do. Petitioner's actions were of no benefit to Berkshire.

In this case, the evidence clearly established the following. First and foremost, Petitioner admits and testimony is confirmed from Berkshire that he was hired in a manual labor position as a meat packer. Petitioner was not hired as a union employee. Berkshire's witness clearly testified regarding the meat packer's job duties. The forklift operator's position is a skilled union job and not something Petitioner was hired for. It is also clear that based on Ian's testimony for Berkshire, Petitioner was clearly outside of his job duties when he was in the hallway, wearing his frock and hairnet, with which he should never have left the boxing room to begin with. Petitioner had no explanation for why he still had on the white frock and hairnet outside of the boxing room. Further, the Arbitrator notes that there was no one around Petitioner in the hallway when he got on the pallet jack/forklift. A viewing of the video itself documents that Petitioner clearly did not know how to operate the pallet jack as he got on. The video at the beginning shows Petitioner going backward and forward while he is trying to figure out how the controls work. Petitioner then goes out of frame for several seconds before he finally comes back into frame, walking behind the pallet jack and not even riding on it as his testimony and histories in medical records allege. Further, Petitioner's testimony was that he was told by Oscar to go into the freezer and obtain the combo to take to the boxing room. When Petitioner comes back into screen on the video, the pallet jack is moving in the appropriate direction and all that Petitioner had to do was simply go straight to go into the freezer room. Petitioner did not do that and made the pallet jack complete a ninety degree left turn as if he intended to proceed down the hallway. It is at this point that Petitioner is walking behind the pallet jack and then backs the pallet jack into himself, causing the injury.

The Arbitrator finds that Petitioner's activities in no way benefited Berkshire. Specifically, Petitioner was performing an activity which was completely against union rules and regulations and subjected Berkshire to the potential of penalties and monetary consequences. The Arbitrator does not believe Petitioner's testimony that someone from Berkshire instructed him to use a pallet jack (which he had not demonstrated any proficiency with) and which use was contrary to the labor agreement and potentially could cause injury to Petitioner or others. Petitioner's testimony was not credible. Petitioner clearly was engaging in an act of horseplay, messing around with the forklift while no one was around and subsequently injured himself, in an action beyond the scope of his employment duties for Berkshire. The accidental injuries did not arise out of his employment by Berkshire.

As the Arbitrator finds that Petitioner's injuries occurred as a result of horseplay that Petitioner was engaged in, the claim for compensation against Berkshire is denied.

With respect to (O) Other, Proof of dependent for benefit rates, The Arbitrator finds as follows:

The Arbitrator finds that there has been a failure of proof as to the dependent status of Tyshanna Jones. The Arbitrator was not persuaded by the testimony of Petitioner and Shandra Jones on this issue. There was no documentary evidence supporting a finding of dependency. Thus, the Arbitrator finds that Petitioner was single, with one dependent under the age of 18 (Dartaniun, Jr.) per the stipulation of Petitioner and Berkshire.

With respect to (F) Causal Connection; (J) and (K) Medical Expenses; and (L) TTD, the Arbitrator finds the following:

As the Arbitrator has found that Petitioner failed to prove that he sustained accidental injuries, arising out of and in the course of his employment by Respondent, Berkshire, the Arbitrator needs not decide the said issues.

STATE OF ILLINOIS)
) SS.
COUNTY OF DUPAGE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

CYNTHIA KACZMARSKI,

Petitioner,

15IWCC0034

vs.

NO: 12 WC 41461

CALVARY CHRISTIAN SCHOOL OF NAPERVILLE,

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 and the nature and extent of Petitioner's permanent disability and being advised of the facts and law, clarifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

In the first paragraph of the Arbitrator's Findings of Fact section, he wrote Petitioner "slipped on water on a tile floor, injuring her left leg and right leg." Thereafter, in the first paragraph of page 2 of that section, the Arbitrator noted that "no claim is being made that the need for the [right knee] arthroplasty was causally related to the accident." In addition, the Arbitrator did not award any permanent partial disability benefits regarding any condition of ill being of Petitioner's right leg.

Respondent takes issue with the sentence in the first paragraph in the Findings of Fact section in which the Arbitrator stated Petitioner injured her right leg in the accident. Respondent asks the Commission to "amend the Decision of the Arbitrator and find that the condition of ill-being if Petitioner's right knee is not causally related to the work accident."

15IWCC0034

Petitioner testified that she injured both her right leg and left leg in her fall at work. The medical records confirm that she complained about increased right leg pain for months following the accident. The Commission also notes that Petitioner was scheduled to have right knee replacement surgery prior to the instant work-related accident. By way of clarification, the Commission finds that the Arbitrator was correct that Petitioner did indeed injure her right leg in the work-related accident. However, the injury constituted only a temporary exacerbation of her preexisting knee condition and did not result in any permanent disability. Therefore, the Arbitrator was correct in not awarding any permanent partial disability benefits for Petitioner's right knee condition.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $398.07 per week for a period of 129 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the permanent loss of 60% of the use of the left leg.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $51,600.00. 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: JAN 20 2015

Ruth W. White

Daniel R. Donohoo

Charles J. DeVriendt

RWW/dw
O-12/17/14
46

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

KACZMARSKI, CYNTHIA
Employee/Petitioner

Case# **12WC041461**

CALVARY CHRISTIAN SCHOOL
Employer/Respondent

15IWCC0034

On 9/26/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% 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:

0222 GOLDBERG WEISMAN & CAIRO LTD
WALTER MROZINSKI
ONE E WACKER DR 39TH FL
CHICAGO, IL 60601

0210 GANAN & SHAPIRO PC
CAROLYN B NOTKOFF
210 W ILLINOIS ST
CHICAGO, IL 60654

15IWCC0034

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

CYNTHIA KACZMARSKI
Employee/Petitioner

v.

CALVARY CHRISTIAN SCHOOL
Employer/Respondent

Case # **12** WC **41461**

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Kurt Carlson**, Arbitrator of the Commission, in the city of **Wheaton**, on **09-10-13**. By stipulation, the parties agree:

On the date of accident, **May 12, 2010**, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $ **34,594.18**, and the average weekly wage was $ **663.45**.

At the time of injury, Petitioner was **57** years of age, ***single*** with **0** dependent children.

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

Respondent shall be given a credit of $ **23,631.44** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**0.00** for other benefits, for a total credit of $**23,631.44**.

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

ORDER

Respondent shall pay Petitioner the sum of $**398.07**/week for a further period of **129** weeks, as provided in Section **8(e)** of the Act, because the injuries sustained caused **the permanent partial disability of the left leg to the extent of 60% thereof.**

Respondent shall pay Petitioner compensation that has accrued from **08-17-11** through **09-10-13**, and shall pay the remainder of the award, if any, in weekly payments.

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

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

Signature of Arbitrator

9-26-13
Date

SEP 26 2013

STATE OF ILLINOIS)
) SS
COUNTY OF DUPAGE)

BEFORE THE WORKERS' COMPENSATION COMMISSION OF THE STATE OF ILLINOIS

CYNTHIA KACZMARSKI,	)	
	)	
Petitioner,	)	
	)	
	)	Case #12 WC 41461
	)	
CALVARY CHRISTIAN SCHOOL OF NAPERVILLE,	)	
	)	
	)	
Respondent.	)	

I. FINDINGS OF FACT

The Petitioner, Cynthia Kaczmarski, is employed by the Respondent, Calvary Christian of Naperville, as a fifth grade teacher. On May 12, 2010 she sustained accidental injuries which arose out of and in the course of her employment. She slipped and fell on water on a tile floor, injuring her left leg and her right leg.

She was transported by ambulance from the school to Rush Copley Medical Center, where she was initially seen in the emergency room. The records reflect a history of Ms. Kaczmarski slipping on water and falling at work. She presented with complaints of pain in the left leg (femur). A diagnosis of a fracture of the left femur was made. The doctor in the emergency room performed a closed reduction of the fracture.

She was then admitted to the hospital as an inpatient from the emergency room. She underwent an open reduction with internal fixation, performed by Dr. Schinsky, on May 13, 2010. The diagnosis was a peri prosthetic left distal femur fracture, with the doctor inserting a plate and multiple screws.

On May 14, 2010 x-rays of her right knee were taken and proved to be negative even though she complained of right knee pain. The Petitioner testified that she had been previously scheduled for right knee arthroplasty by Dr. Paproski in July of 2010. No claim is being made that the need for the arthroplasty was causally related to this accident.

On May 17, 2010 the right knee was aspirated. The Petitioner was then transferred to Rush Copley's rehabilitation unit, where she remained until May 26, 2010. During that time she received inpatient therapy.

On May 26, 2010 the Petitioner was discharged from the rehabilitation unit and transferred to a nursing facility, The Tillers Nursing and Rehabilitation Center, where she remained as an inpatient until July 7, 2010. While in this facility she received after care and additional therapy for the injured member.

Upon her return home from the Tillers, the Petitioner testified that the Respondent's carrier had arranged for the installation of a ramp at her home because she was wheelchair bound. She then began an intensive course of rehabilitation and therapy at Accelerated Rehabilitation, with the initial evaluation taking place on August 3, 2010. She received therapy on a regular basis from that date up through January 19, 2011. Then, on March 14, 2011 a discharge note was created, with the indication that additional physical therapy was placed on hold due to a pending surgery.

She returned to physical therapy on March 30, 2011 and continued receiving physical therapy on a regular basis up through September 13, 2011, at which time she was discharged from therapy.

The Petitioner's medical care for this injury has been through Castle Orthopaedics and Sports Medicine. Initially, Dr. Schinsky performed the open reduction with internal fixation. He

then ordered an MRI of the right knee because of the Petitioner's complaints. That examination was performed on May 15, 2010. The notation was a large supra-patellar joint effusion. Fairly extensive bone bruising was also noted.

The initial post-op visit took place on June 9, 2010 when x-rays of the left femur were taken and then reviewed by Dr. Schinsky. The doctor noted that the Petitioner was wearing her knee immobilizer. He limited her to toe-touch weight bearing. On her return to Dr. Schinsky on June 22nd, the doctor recommended gentile active range of motion exercises but kept the toe-touch weight bearing limitation in place.

She was then seen by Dr. Paras of Castle on June 29, 2010. He reviewed a CT scan, with the findings being consistent with osteoporosis. She was placed on Fosamax for the osteoporosis.

The Petitioner then returned to Dr. Schinsky on July 28, 2010. The x-rays that were taken revealed a minimal amount of evidence of healing of the fracture. Subsequently, on August 2, 2010 Dr. Schinsky prescribed physical therapy, which she began at Accelerated Rehabilitation on August 3, 2010.

She returned to Dr. Schinsky on August 30, 2010. X-rays that were taken showed apparent healing of the fracture. The doctor noted that the Petitioner was now using a walker. She also had complaints of increased right knee pain. The doctor noted an antalgic gait. He ordered additional physical therapy.

The Petitioner then saw Dr. Watkins from Castle on September 16, 2010 for complaints of pain and redness of the right foot. X-rays of the right foot were taken. Dr. Watkins recommended a decrease in weight bearing on the right foot and leg since the Petitioner was over compensating because of the limited weight bearing on the left side.

She returned to Dr. Schinsky on September 28, 2010. Additional x-rays showed some evidence of the fracture healing. She was complaining of pain in the left knee from physical therapy. The doctor ordered a CT scan.

She returned to Dr. Paras on October 2, 2010. This doctor advised her to continue taking the Fosamax for her osteoporosis.

When she returned to Dr. Schinsky on October 8, 2010, he prescribed a bone stimulator. She followed up with him on November 8, 2010. He advised her to continue using the bone stimulator and also to continue physical therapy.

When she returned to Dr. Schinsky on December 3, 2010 additional x-rays showed callus formation around the fracture. He advised her to continue physical therapy and to continue to use the bone stimulator.

She returned to Dr. Schinsky on January 6, 2011 with complaints of deep femoral pain. The doctor ordered a left distal femur CT scan.

When she returned to Castle on January 26, 2011, she saw Dr. O'Connor. His recommendation on that date was bone grafting of the distal femur. However, when she returned to see him on March 18, 2011 he no longer recommended the bone grafting. He ordered a CT scan. She then saw Dr. O'Connor again on March 30, 2011 and the doctor noted significant callus formation. The fracture appeared for the most part to be healed. He recommended an arthroscopy and lysis of adhesions that had developed in the left lower extremity.

On May 3, 2011 the Petitioner was re-admitted to Rush Copley Medical Center and Dr. O'Connor performed a left knee arthroscopy with a diagnosis of left knee arthrofibrosis. She was subsequently discharged from the hospital on May 5, 2011.

Post-operatively she saw Dr. O'Connor on May 18, 2011 and he advised her to continue physical therapy. When she returned to see him on June 9, 2011 the doctor noted that the Petitioner was now using a cane for ambulation and indicated a possible return to work in August of 2011. She saw him again on July 6, 2011 and he ordered continued physical therapy. When he saw her on August 3, 2011 he continued the physical therapy and gave her a release to return to work on August 17, 2011. The Petitioner did in fact return to work on August 17, 2011.

The Petitioner followed up with Dr. O'Connor on September 15, 2011, at which time physical therapy was discontinued. When she returned to the same doctor on October 26th, the doctor noted she was working her regular job. He also noted that she was using a cane. The x-rays that were taken showed that the fracture had healed solidly. He pronounced her to be at MMI.

She returned to see him on December 28, 2011, at which time he advised her to continue her home exercise program and to follow up with him in a year.

The Petitioner returned to Dr. O'Connor for the last time on May 1, 2013. The doctor noted that she was still using a cane. He noted flexion of the left leg to 80° and full extension. The x-rays that were taken showed the fracture to be completely healed and the knee prosthesis to be in good position. He again pronounced her at MMI and told the Petitioner to see him PRN.

II. CONCLUSIONS OF LAW

NATURE AND EXTENT OF THE INJURY

Based upon the evidence presented at Arbitration, the arbitrator finds that the Petitioner is entitled to receive from the Respondent the sum of $398.07 per week for a period of 129 weeks

because the Petitioner has sustained permanent partial disability of the left leg to the extent of 60% thereof pursuant to Section 8(e) of the Act.

The Petitioner has undergone two surgical procedures involving the left leg, the first being the open reduction with internal fixation performed by Dr. Schinsky on May 13, 2010. The second surgery was performed by Dr. O'Connor on May 3, 2011, an arthroscopy and debridement of fibrosis in the knee joint.

Although the Petitioner had a left knee arthroplasty in 1994, she testified credibly that once her treatment program was finished for that surgical procedure she had no difficulties in performing her job and in going about her activities of daily living. However, since the accident in this case, the Petitioner has been unable to ambulate without some sort of assistive device. Initially, she used a wheelchair, then changed over to a walker, which she used for an extended period of time, then transitioned to crutches and finally a cane. She continues to use the cane up to the present day.

She testified that her current complaints involving her left leg include a pain level of anywhere from 5 to 10. Getting in and out of a car causes her extreme difficulty as does the climbing of stairs. This activity causes an increase in her pain level. She also testified that walking causes her pain, with the pain being experienced in the upper thigh of the left leg. She testified that she did not experience this type of pain prior to the date of the accident. She further testified that she takes over the counter Tylenol, 4 to 6 tablets per day, 650 mm each. She did not take this type of medication prior to May 12, 2010.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

RONALD BERRYHILL,
Petitioner,

15IWCC0035

v

No. 03 WC 56216

STATE OF ILLINOIS – TOLL HIGHWAY AUTHORITY,
Respondent.

OPINION AND DECISION ON PETITION UNDER §§19(h) & 8(a)

This matter comes before the Commission on Petitioner's Petition under §§19(h) and 8(a). In the underlying cases, the Arbitrator issued a Forth Corrected Decision on May 19, 2009, in which he found Petitioner suffered a work-related accident on August 5, 2003 and awarded him 275&4/7 weeks temporary total disability benefits, $8,830.98 in medical expenses, 250 weeks of permanent partial disability benefits representing 50% loss of the person-as-a-whole, and $3,390.00 in penalties under section 19(l).

Respondent sought review of the Decision of the Arbitrator. On review the Commission modified the Decision of the Arbitrator to reduce the award of temporary total disability benefits to 109 weeks, to reduce the award of medical expenses to $6,751.23, to reduce the award of permanent partial disability benefits representing 40% loss of the person-as-a-whole, and to vacate the award of penalties.

In significantly reducing the Arbitrator's award to Petitioner, the Commission found not credible Petitioner's testimony regarding Respondent's failure to abide by work restrictions and his explanation for his suboptimal effort as found in a functional capacity evaluation. The Commission also found that Petitioner's condition "clearly stabilized by" August 22, 2008 and that by that time he was selling cars and incorporated his own business. It used the positive Waddell signs in the functional capacity evaluation and surveillance video to reduce his permanent partial disability award from 50% loss of the use of the person-as-a-whole to 40%. The Commission concluded that "petitioner had a more favorable recovery from his accident and surgery than he wishes to show."

15IWCC0035

Hearings on the instant petition were held on February 14, 2014 and April 10, 2014 in Chicago before Commission White. Respondent was represented by counsel, Petitioner appeared *pro se*, and a record was taken. At the first hearing, Petitioner indicated he wanted to depose Respondent's Section 12 medical examiner, Dr. Delheimer, and the matter was continued. However, in the interim, Dr. Delheimer died. Dr. Delheimer's Section 12 examination report was admitted into evidence as well as medical records from after the arbitration.

Findings of Fact and Conclusions of Law

1. On January 5, 2012, Dr. An issued an open letter indicating Petitioner was under his care. He diagnosed foraminal stenosis at the left at L4-5 after a recent CT. He recommended an injection.

2. On September 12, 2012, Dr. Mace issued an open letter indicating he was Petitioner's general practitioner and was treating him for various conditions including managing his pain from his back injury in November of 2003. Dr. Mace noted that he continued to have considerable pain in his cervical and lumbar spine from the injury. The surgery did not provide relief.

3. On September 17, 2012, Dr. An issued an open letter indicating Petitioner did not need surgery but did need pain management because his condition was worsening due to chronic pain including nerve pain, due to nerve damage that evolved from his lumbar spine condition. Petitioner had fusion surgery in 2007 and he reported his symptoms started from a work injury in 2003.

4. On September 21, 2012, Dr. Deutsch issued an open letter indicating Petitioner presented to neurosurgery and had ongoing back and neck pain which he related to an accident in November 2003. Dr. An performed surgery on his lower back in 2007 and told him he had nerve damage. Dr. Deutsch indicated Petitioner was at maximum medical improvement.

5. On September 3, 2013, a CT/myelogram showed good posterior fusion at L5-S1 and partial laminectomies at L3-5, intact stable fusion hardware with good decompression of the spinal canal, lumbar spondylotic changes with mild multilevel facet arthropathy and ligamentum flavum thickening, combination of disc bulge and facet arthropathy causing mild to moderate foraminal stenosis L3-5 and moderate foraminal stenosis at L5-S1, and lumbar lordosis with minimal retrolisthesis of L5 on S1 and L3 on L4.

6. On September 6, 2013, Dr. An issued a statement indicating the September 3, 2013 CT/Myelogram was ordered due to persistent chronic back and leg pain. The CT indicated the decompression and fusion were quite adequate and no additional surgery was indicated. Dr. An opined that Petitioner's symptoms were permanent and he recommended specialized pain management.

7. On August 12, 2013, Dr. Delheimer issued a medical examination report pursuant to Section 12 of the Act. Dr. Delheimer noted he had previously examined Petitioner in September of 2007 regarding an alleged work injury on July 22, 2003. He did another IME on August 9, 2013 and reviewed additional medical records. Dr. Delheimer indicated Petitioner voluntarily limited his range of motion in his back. He had negative straight leg raise tests and normal reflexes.

8. Dr. Delheimer also noted that Petitioner exhibited "excessive grunting and grimacing, as well as excessive pain manifestations during the entire exam as well as while walking onto and out of the exam room." His complaints were all subjective and there were no new objective findings since his previous examination in 2007. There was "no medical reason to increase his previous" permanent partial disability award.

9. Dr. Delheimer then answered interrogatories. He opined that Petitioner's current complaints were due to underlying degenerative disc disease with a component of excessive pain manifestation and were not caused by the 2003 accident; there were no new objective findings since his previous examination in 2007 or since the case was arbitrated in 2009. The diagnostic studies indicated that Petitioner's condition was stable since 2009.

In his brief, Petitioner simply attacks the report of Dr. Delheimer indicating he "falsified" information and Petitioner "certified" that he was not examined by Dr. Delheimer in 2007. He was "definitely not telling the truth" and made "false accusations." Petitioner also included in his brief additional medical records and letters from treaters which were not submitted into evidence at the review hearing.

The Commission finds that that Petitioner has not sustained his burden of proving that he suffered any increased disability since the case was arbitrated or indeed that any current condition of ill being is related to his 2003 accident. Even if Petitioner does actually have ongoing complaints and/or continued disability related to his 2003 accident, such ongoing problems would be expected for a claimant who was awarded 40% loss of the use of the person-as-a-whole for a spinal injury.

In the previous decision the Commission clearly had difficulty accepting the veracity of Petitioner's testimony. Petitioner appeared to have exhibited symptoms exaggeration throughout. The Commission specifically found that Petitioner's condition had stabilized as of August 22, 2008 and Dr. Delheimer specified that objective findings and imaging tests showed no change in Petitioner's condition since 2009, when the case was arbitrated. In addition, the notes/letters submitted by Petitioner do not include any definitive statement of a medical opinion indicating the 2003 accident/injury caused his current complaints. They generally simply indicated that Petitioner complained of continuing symptoms which Petitioner himself related to his accident. The Commission concludes that these vague notations do not sustain Petitioner's burden of proving the elements necessary to receive additional compensation pursuant to this petition.

15IWCC0035

IT IS THEREFORE ORDERED BY THE COMMMISSION, that Petitioner's Petition for Relief Pursuant to §§19(h) & 8(a) is hereby denied.

DATED: JAN 20 2015

Ruth W. White

Daniel R. Donohoo

Charles J. DeVriendt

RWW/dw
D-12/17/14
46

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JUANA E. GALDAMEZ,

Petitioner,

vs. NO: 12 WC 24018

ENAMELED STEEL & SIGN CO.,

15IWCC0036

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of causation, medical expenses, temporary total disability (TTD) and prospective 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 modifies the decision of the Arbitrator and finds that the causal connection of Petitioner's low back condition ended as of November 4, 2013.

Hearing was held on this matter pursuant to Section 19(b) on November 2, 2012. A decision was issued by the Arbitrator on December 27, 2012 finding Petitioner sustained accidental injury to her low back arising out or and in the course of her employment with Respondent on May 23, 2012, and awarded TTD, medical expenses and prospective lumbar epidurals as prescribed by Dr. Sokolowski. Subsequent to the initiation of epidural injections, Dr. Sokolowski prescribed lumbar decompression surgery. Respondent disputes the causal relationship of this prescription to the May 23, 2012 accident.

Petitioner testified that she had temporary relief with an initial February 29, 2013 epidural injection. She also continued to work light duty and attend physical therapy. A back brace was prescribed on May 8, 2013, which provided Petitioner with some pain relief. Dr.

Sokolowski took her off work completely on June 17, 2013, and Petitioner testified that a second epidural performed on June 28, 2013 provided no symptomatic relief. Following a repeat lumbar MRI on August 8, 2013, Dr. Sokolowski prescribed decompression surgery at the L4/5 level. Petitioner has not returned to work since June 17, 2013.

On cross examination Petitioner agreed she underwent more aggressive therapy via work conditioning in August and September of 2013, and she was aware the purpose of this treatment was to increase her physical capabilities and return her to regular work duties. She agreed that her regular duties required her to be able to lift up to 25 pounds. While the work conditioning therapy records indicated Petitioner's job required her to be able to lift up to 50 pounds, the Petitioner testified that this was incorrect.

On August 2, 2012, orthopedic surgeon Dr. Sokolowski noted Petitioner's exam reflected decreased sensation in the right L5 and S1 dermatomes with normal strength and reflexes. He opined that a June 2012 MRI showed L4/5 herniation with resultant neural impingement, and a smaller L1/2 herniation. He diagnosed lumbar radiculopathy secondary to the L4/5 herniation and prescribed epidural injections. Once this was approved following the prior 19(b) hearing, bilateral epidurals were performed on or about February 19, 2013. Petitioner continued physical therapy between August 2012 and February 2013 (Petitioner's Exhibit 3), but reported minimal improvement. On March 19th Petitioner reported some improvement with the epidurals, but that the pain returned when she returned to light duty work. On April 8, 2013 Petitioner had improved enough that she requested increase her lifting capabilities at work. She wanted to wait on a second epidural. On June 17, 2013 Dr. Sokolowski stated that Petitioner was worse and wanted the second epidural. She was taken off work and the injection was performed on June 28th, after which Petitioner reported temporary relief.

MRI was prescribed and performed on August 8, 2013, indicating that the L2/3, L3/4 and L5/S1 levels were unremarkable, and the L1/2 and L4/5 levels were unchanged when compared to the June 27, 2012 MRI films. The June 27, 2012 MRI report reflected a subligamentous posterior central disc herniation (4-5mm) at L4/5 elevating the posterior longitudinal ligament and indenting the thecal sac without significant spinal or foraminal stenosis, and a subligamentous posterior central disc protrusion / herniation (3-4mm) at L1/2 which slightly elevates the posterior longitudinal ligament and indents the thecal sac without significant spinal or foraminal stenosis. (Petitioner's Exhibit 2).

On August 2, 2013, prior to the MRI, Dr. Sokolowski prescribed work hardening, at the recommendation of the physical therapist, and kept Petitioner off work. A functional capacity evaluation (FCE) was performed on September 5, 2013 (Petitioner's Exhibit 3). Petitioner was found to be at the medium physical work level and capable of doing 88.6% of her job. A Dictionary of Occupational Titles job classification indicated her job classificatioon required lifting up to 20 pounds, and that it fell within the medium physical work level. However, the report states that the job demands "gathered from client" indicated Petitioner had to lift up to 50 pounds at work.

On September 6, 2013 Dr. Sokolowski stated that the updated MRI showed L5/S1 herniation with neural impingement. He indicated Petitioner's pain was hard to manage and she

was apprehensive about returning to regular duty work. Pain management was prescribed, noting if she ultimately failed conservative treatment, L4/5 decompression could be prescribed, and she was continued off work. On October 4, 2013, Petitioner indicated she was "giving considerable thought to pain management in perpetuity versus more definitive management", and wanted to undergo surgery. Dr. Sokolowski then noted decreased sensation in the L4 and L5 dermatomes. At the last visit of January 24, 2014, Dr. Sokolowski noted he reviewed the report of Dr. Ghanayem and disagreed with Ghanayem's impression that there was no herniation at L4/5, noting "the patient has clear evidence of ongoing radiculopathy", and that the FCE indicated Petitioner was not capable of full duty despite Dr. Ghanayem's opinion that she was. He continued Petitioner off work pending surgery.

Petitioner was examined by orthopedic surgeon Dr. Kornblatt on August 16, 2012 at the request of Respondent. He reviewed the June 27, 2012 lumbar MRI and indicated it showed disc desiccation at L1/2 and L4/5 with some loss of disc height, but no frank disc herniation, spinal stenosis or nerve root impingement. He opined that the accident resulted in a lumbosacral strain with symptoms of mechanical low back pain, referred right leg pain, and exacerbation of preexisting L4/5 degenerative disc disease. However, Dr. Kornblatt reported that Petitioner had no abnormal physical findings on examination, and opined as follows: "The only treatment indicated is for the patient to resume her normal lifestyle as soon as possible. This would include gainful employment along with an active exercise routine to include core and low back stabilization exercises and aerobic conditioning, which the patient may perform on her own as she has undergone appropriate formal physical therapy up until today's date. Clinically the patient does not present with a clinical radiculopathy and warrants no invasive treatment referable to the lumbar spine."

Following Dr. Sokolowski's October 4, 2013 surgical recommendation, Respondent referred Petitioner for a Section 12 examination with orthopedic surgeon Dr. Ghanayem on November 4, 2013. Petitioner reported back pain radiating up her spine to the cervical base, right greater than left, with cramping in the posterior left thigh and circumferentially below the left knee. Dr. Ghanayem noted a normal neurological exam and multiple inconsistent findings. He opined that lumbar MRI films reflected mild disc degeneration at L1/2 and L4/5. He stated that these were no disc herniations at these levels: "These are not disc herniations. I disagree with the report entirely talking about the 3-4 mm disc herniation at L1/2, and a 4-5 mm disc herniation at L4/5. These are degenerative findings. There is no neurologic compression whatsoever." He opined that Petitioner may have suffered a back strain, but that she had age appropriate degenerative changes, no traumatic findings and multiple nonorganic physical findings consistent with symptom magnification. He believed she had reached maximum medical improvement and needed no further treatment, including the surgery that had been prescribed.

Based on a review of all of the evidence, the Commission finds that the causal relationship of the Petitioner's low back condition to the May 23, 2012 accident ended as of the November 6, 2013 report of Dr. Ghanayem. It appears that only Dr. Sokolowski has opined that the Petitioner has neural impingement. Dr. Kornblatt, Dr. Ghanayem and the MRI radiologist all have indicated no evidence of neural impingement, either clinically or diagnostically on the MRI films. We find that the accident aggravated a preexisting degenerative lumbar condition, and that the Petitioner has reached maximum medical improvement.

It is difficult for the Commission to make findings in cases where different doctors read objective films differently. Here, Dr. Sokolowski is alone in finding objective evidence of neural impingement. As such, the Commission finds the preponderance of the evidence indicates that there is no true objective evidence of neural impingement.

Additionally, the Commission has some questions with regard to the Petitioner's credibility. First, it appears that she indicated to the physical therapist performing the FCE that her job required dealing with boxes weighing up to 50 pounds. In her testimony, the Petitioner agreed that she actually only had to lift up to 25 pounds. This is a large discrepancy, especially in that her ability to return to work was significantly dependent on this determination. In reviewing the report of Dr. Kornblatt, his recommendation that Petitioner "resume her normal lifestyle as soon as possible" appears to be a diplomatic way of saying that there were no significant findings and that the Petitioner needed to recondition to her normal work and non-work activities. Dr. Ghanayem then indicates that the Petitioner had multiple inconsistencies on examination, consistent with symptom magnification. It is clear based on our review of Dr. Sokolowski's records that the surgical recommendation is significantly based on the Petitioner's subjective complaints, and her subjective election to pursue such treatment. We also note that Dr. Sokolowski's records are somewhat inconsistent in that he initially found loss of sensation in L5 and S1 distributions, then later finding it in L4 and L5 distributions. Dr. Sokolowski's records note he agreed with the MRI radiologist's findings of herniation and "resultant neural impingement". In reviewing the MRI reports, the radiologist, Dr. Kuritza, specifically indicated in both lumbar MRI reports that the L4/5 disc was central and without significant spinal or foraminal stenosis, which is in agreement with the opinions of Dr. Kornblatt and Dr. Ghanayem.

Based on the Commission's finding regarding causation, we find that Respondent is liable for TTD and medical benefits through November 6, 2013 only. Petitioner's claim for TTD, medical expense coverage and prospective medical treatment after that date is denied.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator is modified as noted above.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $317.61 per week for a period of 20-1/7 weeks, from June 17, 2013 through November 4, 2013, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the costs of medical care rendered to the Petitioner from November 2, 2012 through November 4, 2013 pursuant to §8(a) of the Act, and subject to the fee schedule contained in §8.2 of the Act.

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

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is entitled to a credit for any awarded causally related medical expenses paid by Respondent pursuant to §8(j) of

15IWCC0036

the Act; provided that Respondent shall hold Petitioner harmless from any claims and demands by any providers of the benefits for which Respondent is receiving credit under this order.

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $6,500.00. 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: JAN 20 2015
TJT: pvc
o 11/18/14
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

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

GALDAMEZ, JUANA
Employee/Petitioner

Case# **12WC024018**

ENAMELED STEEL & SIGN CO
Employer/Respondent

15IWCC0036

On 2/27/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.07% 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:

0815 LUIS A ACEVES & ASSOC PC
EMILIANO PEREZ JR
1931 N MILWAUKEE AVE
CHICAGO, IL 60647

0766 HENNESSY & ROACH PC
PETER J PUCHALSKI
140 S DEARBORN ST 7TH FL
CHICAGO, IL 60603

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

STATE OF ILLINOIS)
)
COUNTY OF COOK)

15IWCC0036

ILLINOIS WORKERS' COMPENSATION COMMISSION

19(b) ARBITRATION DECISION

JUANA GALDAMEZ
Employee/Petitioner

Case #12 WC 24018

v.

ENAMALED STEEL & SIGN CO.,
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Robert Williams, arbitrator of the Workers' Compensation Commission, in the city of Chicago, on February 18, 2014. After reviewing all of the evidence presented, the arbitrator hereby makes findings on the disputed issues, and attaches those findings to this document.

ISSUES:

A. ☐ Was the respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?

B. ☐ Was there an employee-employer relationship?

C. ☐ Did an accident occur that arose out of and in the course of the petitioner's employment by the respondent?

D. ☐ What was the date of the accident?

E. ☐ Was timely notice of the accident given to the respondent?

F. ☒ Is the petitioner's present condition of ill-being causally related to the injury?

G. ☐ What were the petitioner's earnings?

H. ☐ What was the petitioner's age at the time of the accident?

I. ☐ What was the petitioner's marital status at the time of the accident?

J. ☒ Were the medical services that were provided to petitioner reasonable and necessary?

K. ☒ What temporary benefits are due: ☒ TPD ☐ Maintenance ☒ TTD?

L. ☐ Should penalties or fees be imposed upon the respondent?

M. ☐ Is the respondent due any credit?

N. ☒ Prospective medical care?

FINDINGS

- A Section 19(b) arbitration decision was filed on December 27, 2012, pursuant to a hearing on November 2, 2012.

- The petitioner was awarded temporary total disability benefits from August 2 through October 7, 2012, the cost of the reasonable and necessary medical services and epidural injections prescribed by Dr. Sokolowski for her low back injury.

- The parties agreed that the respondent paid $9,982.36 in temporary total disability benefits.

ORDER:

- The respondent shall pay the petitioner temporary total disability benefits of $317.61/week for 35-2/7 weeks, from June 17, 2013, through February 18, 2014, which is the period of temporary total disability for which compensation is payable.

- The cost of the medical care rendered the petitioner from November 2, 2012, through February 18, 2014, is awarded. The respondent shall pay the medical bills in accordance with the Act and the medical fee schedule. The respondent shall be given credit for any amount it paid toward the medical bills, including any amount paid within the provisions of Section 8(j) of the Act, and any adjustments, and shall hold the petitioner harmless for all the medical bills paid by its group health insurance carrier.

- The petitioner is entitled to have from the respondent the reasonable and necessary cost for a lumbar decompression at L4-5.

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

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

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

Robert E. Williams
Signature of Arbitrator

February 27, 2014
Date

FEB 27 2014

FINDINGS OF FACTS:

On November 9, 2012, the petitioner returned to Dr. Sokolowski and reported persistent back symptoms with bilateral radiation into buttocks and lower extremities, right greater than the left. The doctor noted the petitioner's physical examination had not changed since October 5, 2012. The petitioner had bilateral transforaminal epidural steroid injections at L4-5 on February 19, 2013, that provided a slight relief for a short period. The petitioner reported some improvement on April 8th and expressed a desire to increase her lifting limit to fifteen pounds. Her symptoms were unchanged on May 8th and progressively worse on June 17th, at which time Dr. Sokolowski recommended no work.

The petitioner had bilateral transforaminal epidural steroid injections at L4-5 on June 28th. On July 23rd, she reported short-term relief with the injections but no lasting relief and an increase in her back pain the day prior. Work hardening was started on August 2nd. An MRI on August 8th revealed no significant changes from the MRI on June 27, 2012. On October 4th, the petitioner requested to proceed with a lumbar decompression at L4-5. Dr. Ghanayem performed a Section 12 examination of the petitioner on November 4th and opined that there are no disc herniations revealed on the MRIs but degenerative findings at L1-2 and L4-5, the petitioner was at MMI and could return to regular work duties and the petitioner presented nonorganic physical findings consistent with symptom magnification. The petitioner reported developing neck concurrently with her back pain on November 8th. Dr. Sokolowski reiterated his recommendation for a lumbar decompression at L4-5 at her last follow-up on January 24, 2014.

FINDING REGARDING WHETHER THE MEDICAL SERVICES PROVIDED TO PETITIONER ARE REASONABLE AND NECESSARY:

The medical care rendered the petitioner from November 2, 2012, through February 18, 2014, was reasonable and necessary and the cost of the medical care is awarded.

FINDING REGARDING WHETHER THE PETITIONER'S PRESENT CONDITION OF ILL-BEING IS CAUSALLY RELATED TO THE INJURY:

Based upon the testimony and the evidence submitted, the petitioner proved that her current condition of ill-being with her low back is causally related to the work injury.

FINDING REGARDING THE AMOUNT OF COMPENSATION DUE FOR TEMPORARY TOTAL DISABILITY:

Although Dr. Sokolowski recommended no work after the epidural injection on February 19, 2013, the petitioner worked part-time from February 21 through 27, 2013, and is entitled to temporary partial disability benefits based on part-time earnings of $267.00. Two-thirds of her full wages ($480.00) minus her part-time wages ($267.00) is $142.00. The respondent shall pay the petitioner temporary partial disability benefits of $142.00 for the week of February 21 through 27, 2013, as provided in Section 8(a) of the Act.

Pursuant to Dr. Sokolowski's recommendation the petitioner did work after June 16, 2013. The respondent shall pay the petitioner temporary total disability benefits of $317.61/week for 35-2/7 weeks, from June 17, 2013, through February 18, 2014, as provided in Section 8(b) of the Act, because the injuries sustained caused the disabling condition of the petitioner.

FINDING REGARDING PROSPECTIVE MEDICAL:

The petitioner proved that the lumbar decompression at L4-5 recommended by Dr. Sokolowski is reasonable medical care necessary to relieve the effects of the work injury to her lower back. The petitioner is entitled to have from the respondent the reasonable and necessary cost for a lumbar decompression at L4-5.

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

Curtis Simpson,
Petitioner,

vs.

NO: 08 WC 22849

City of Peoria,
Respondent,

15IWCC0037

DECISION AND OPINION ON REVIEW

Respondent appeals the decision of Arbitrator Dollison finding Petitioner sustained an accidental injury arising out of and in the course of his employment on January 12, 2008. The Arbitrator found Petitioner is permanently disabled to the extent of 25% man as a whole under Section 8(d)2 of the Illinois Workers' Compensation Act. The main issue on Review is whether Petitioner's claim is compensable. The Commission, after reviewing the entire record, reverses the Arbitrator's decision and finds that Petitioner failed to meet his burden of proof.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission finds:

1. Petitioner was a 63 old year firefighter on January 12, 2008. He testified he began working for Respondent in 1976 as a hoseman. He then progressed to being a firefighter/fire engineer/basic life support (BLS) person, which is currently known as a first responder. During the first 2/3 of his career he worked as a front line/line of duty firefighter. He performed this job for 22 years in all. During this time he was subjected to smoke, toxins, alarms, shift work, disruptive sleep, a high degree of anxiety/adrenalin rushes and all sorts of medical calls. He worked a 24 on and 48 hour off shift. He spent the last 1/3 of his career as an administrative officer. He performed this job for 11 years. He worked as a captain, a Battalion Chief, a Division

Chief and finally as an Assistant Chief. The more he advanced in the ranks the further removed he became from the front line. As he rose in the ranks he was more responsible for the safety of other firefighters and the operation of the department as a whole. He last worked as a firefighter in 2008 performing administrative/managerial functions that were more sedentary in nature. At the time of the alleged accident he was working as an Assistant Fire Chief and with the exception of being "on-call" as a division chief every other month he worked an 8 a.m. -5 p.m./40 hour a week shift. He witnessed both good and bad things during his career. He never sought psychological treatment.

2. On January 12, 2008, Petitioner was at home. Petitioner testified that earlier in the day he had cleaned his garage. He said he had been sweeping and cleaning up materials. In particular, he moved an approximately 50 pound bag of bird seed. Petitioner said he moved ½ a bag of bird seed and then rolled a cart with more bird seed out of the way. Petitioner subsequently told Dr. Weaver, the independent medical examiner hired by Petitioner, that he slid the bag of bird seed. The Proctor Hospital records from that day show Petitioner was working in his garage at home cleaning and carrying some wood and other objects. A second history showed he was lifting fertilizer and heavy bags of birdseed. Petitioner testified that after cleaning his garage, he took a shower in his house. During the shower he felt some pain. After the shower he was sitting and talking but the pain did not go away so he laid down on his bed. His girlfriend came in and asked him what was the matter. He told her about the pain and she took him to the hospital. Dr. Gumm, a cardiologist, told him he had a heart attack. Petitioner underwent surgery at that time with a second surgery a year later. A stent was put in each time. Post surgery, he went through rehabilitation. He was not allowed to return to work as a firefighter because he was taking Plavix, a blood thinner. He retired in 2008 at the age of 63. Mandatory retirement is 66. It is his personal choice to currently not work. He regularly sees a cardiologist in Arizona. He is not having any current problems. He golfed, using a cart, until he experienced a pinched nerve in his back. He still rides a motorcycle.

3. Petitioner testified that at the time of the heart attack he was on medication for hypertension for high blood pressure and hyperlipidemia/high cholesterol. He was also taking Morvasc, Atenolol and Lipitor. He reported to his doctor that his mother had hypertension. He testified that at the time of the heart attack he was overweight. He further testified that he is a nonsmoker and consumes alcohol on a rare basis. Petitioner said while he was tested for sleep apnea, he was never treated for the same.

4. On April 30, 2008, Dr. Ayers performed a Pension Board Examination. Dr. Ayers noted Petitioner's medical records showed he had an 80% stenosis in the right coronary artery, 40-60% stenosis in the left artery and 40-50% stenosis in the left circumflex artery. He noted that Petitioner was cleaning his garage on January 12, 2008 at the time of the heart attack. On reviewing the assistant fire chief essential job functions, Dr. Ayers noted that this position required administrative skills and it did not appear that physically performing fire suppression was required for this position. Dr. Ayers opined that Petitioner seemed to have had a good response from his stenting and with ongoing medical care he should be able to manage his risk

factors. However, if he were classified as a fireman doing fire suppressive activities, then this would not be the case. Dr. Ayers noted that Petitioner had been given the impression by his fire chief that he could not return to work since he had sustained a heart attack, was stented and taking Plavix.

5. On July 15, 2008 Dr. Scott evaluated the Petitioner. Dr. Scott opined that Petitioner had coronary artery disease associated with personal risk factors and a coronary event at home while doing strenuous activities. It would not appear medically valid to assume his cardiac event occurred solely due to his occupation as a firefighter while ignoring valid risk factors of age, sex, hyperlipidemia and a long history of hypertension. Dr. Scott opined that Petitioner was able to safely perform his duties if his real job and functional demands were based on his current job description of Assistant Fire Chief. Based on his medical records there would be no technical reason why he could not return to work. Lastly, based on Petitioner's personal risk factors, the non-work location and activities at the time of the event, Dr. Scott did not see any on-the-job incident that caused the coronary event.

6. On November 29, 2012, Dr. Fintel was deposed. He has a medical degree from Harvard. He performed a 3 year internship and residency at Mt. Sinai Hospital in internal medicine. He had completed a 3 year fellowship in cardiovascular diseases at John Hopkins. He joined the faculty at the Northwestern University School of Medicine in 1985. Over the past 28 years, he has moved up the academic ranks to a professor of medicine. He specializes in cardiovascular disease. He is board certified in cardiovascular diseases, nuclear cardiology, internal medicine and critical care medicine. In a typical work week, which is 60-70 hours, 80% of his time is clinical in nature.

Dr. Fintel noted from his report that Petitioner was a longstanding member of the fire department with 22 years as a fire fighter and 10 years as an assistant fire chief. He has a longstanding history of a number of important and interrelated cardiac risk factors, including high blood pressure/hypertension, hyperlipidemia, and obesity. His obesity led to obstructive sleep apnea, which itself can lead to a progression of coronary disease. He has left buddle branch block in which there has been some damage to the conducting system of the heart so that the pattern of depolarization of the heart muscle is abnormal on the EKG. He has a history of heart disease in his family, primarily his mother. Petitioner's cardiac symptoms occurred while he was at home, off duty, and performing physical labor on his own accord. Petitioner reported his chest discomfort came on in the shower after he was working in his garage with heavy items. Dr. Fintel did not believe the cardiac event was caused or precipitated by Petitioner's work as a fire fighter. The medical records strongly suggest that the event of January 12, 2008 was due to a progression of coronary atherosclerosis (narrowing of the arteries) which in turn was the result of underlying risk factors. Dr. Fintel noted that Petitioner had significant risk factors for coronary artery disease which are hypertension, hyperlipidemia, mild family history and his gender. He was "essentially a powder keg waiting to explode". The events that occurred while working in his garage on January 12, 2008 were a culmination of that process and the mild heart attack that resulted was a direct correlation or consequence of his risk factors leading to his underlying

coronary disease. Based on his symptom-limited exercise performance, he would allow Petitioner to exercise on a regular basis to the point of exhaustion and to do ordinary work, including administrative work. He would leave it up to the fire department to determine whether Petitioner could function as a fireman on the line. Dr. Fintel understood that for the past few years Petitioner was no longer actively engaged in fighter fighting and he was presumably in an administrative capacity.

7. Dr. Weaver was deposed on September 13, 2013. She testified she is a doctor of public health at Johns Hopkins University in the Bloomberg School of Public Health. She received her medical degree from New York University. After medical school she completed a residency in internal medicine at Case Western Reserve University and at John Hopkins University in occupational and environmental medicine. She then completed a research fellowship at Johns Hopkins University. After that she joined the faculty there. She is board certified in internal and occupational medicine. She also holds an appointed position in the School of Medicine. She directs the occupational and environmental medicine training program for physicians at Johns Hopkins and she is on the faculty in the Welch Center for Prevention, Epidemiology and Clinical Research. She is a member of several societies and is on many advisory panels. The most pertinent is the medical advisory board of the International Association of Fire Fighters (I.A.F.F.) The I.A.F.F. has a long standing relationship with the Bloomberg School of Public Health. There is a contractual agreement that firefighters' funds are transferred to the school in exchange for residents rotating at the I.A.F.F. to assist with questions of causation.

Dr. Weaver prepared a report in regard to Petitioner. She reviewed a DVD from Proctor Hospital in regard to Petitioner's admission, the medical records from Drs. Malik and Gumm, his cardiologists, a report from Dr. Fintel along with his deposition and a report from Dr. McDowell, who is a resident at I.A.F.F. She also had a telephone interview with Petitioner on September 6, 2013 in order to get an understanding of his work career and specific issues in the job that could have resulted in exposure for him to fire fighting hazards that can result in cardiovascular disease.

Petitioner reported working 22 years as a full-time fire fighter capped off in the last 9 years as a working chief who was on call every other month. His firehouse was one of the busiest in the City of Peoria and he worked a wide range of fires. He worked a 24 hours on/48 hour off schedule. Because the station was busy, he did not get much sleep when he was on duty. Also, the city had a fire alarm system that would be activated in all the fire stations when only one station was being called to respond, which meant that all the firefighters would wake up every time there was a fire anywhere in the city. If they had to respond they would go from a dead sleep to being ready to put out the fire in four minutes, which was very stressful. Petitioner was subjected to smoke, chemicals, noise of the sirens, structural sounds of the fire and the alarm system. He listed many reasons why occupational stress is a real concern for fire fighters. He was an active fire fighter dealing with adults and children dying. As a result of being a chief, he was responsible for protecting his work force and he had ongoing daily concerns about the safety of those under him.

Petitioner pointed out an inaccuracy in the medical records from the day of his heart attack. He said he had been sweeping his garage and was not lifting but had just slid one 50 pound bag of birdseed. Petitioner further related the heart attack followed what he described as not very intense physical activity. He had a myocardial infarction (MI) diagnosed by elevated cardiac enzymes but there were no changes on his EKG. He was treated by a stent being put into right coronary artery. Petitioner said he could not remember the most recent fire exposure he had before the event. He noted as chief he pretty much went to all the fires, whether he was on call or not because he was dedicated to his job and concerned about the safety of those under him.

In reviewing his medical records and in talking to Petitioner it was clear he had a history of hypertension, hyperlipidemia, obesity, chronic occupational exposure from fire fighting in terms of chemicals, stress, noise and disrupted sleep, age and diet. He was never a smoker, not a diabetic and had no family history other than his mother having hypertension. She opined that for firefighters who have a cardiac event within 24 to 48 hours after a fire exposure, it is very clear that it is work related. The doctor addressed a large body of literature that focuses on the range of hazards in chemical asphyxiants such as carbon monoxide leading to cardiac risks. She noted that Petitioner's work schedule was highly irregular and he could be awake for 24 hours. She noted that shift work, sleep disturbances and noise exposure have been correlated with hypertension, diabetes, obesity and heart disease. Noise exposer is associated with hypertension, which is a risk factor for heart disease. Studies have shown that those who have heart attacks/MIs are twice as likely to report chronic stress. Firefighters are exposed to many traumatic life events so they are at risk for post traumatic stress disorder (PTSD) and patients who have PTSD often have increased blood pressure which can lead to hypertension or heart disease. Dr. Weaver thought Petitioner also had chronic stress exposures worrying about the fighter fighters under him and having been personally exposed to some very distressing events. She conceded that Petitioner's MI was not the result of an acute cardiac event directly related to fire suppression activity. However, because of Petitioner's 31 years of exposure to chronic risk factors, Dr. Weaver believed that his occupation might have been a cause of his MI.

On cross-examination, Dr. Weaver acknowledged that she is not board certified in cardiovascular disease, nuclear cardiology or critical care medicine. She only spends 5-10% of her time treating patients and she does not treat any patients for cardiovascular disease. She is a causation expert. She said she focused on the medical aspects for fighter fighters so she really does not know the details of the administrative response to fire fighting. She agreed that Petitioner's MI was not the result of an acute cardiac event directly related to a fire suppression activity. The most likely scenario is that Petitioner had chronic exposure which contributed to his cardiovascular disease. Dr. Weaver did not discuss the specifics of Petitioner's sleep disruption in the last 9 years. She was not provided with any specifics information as to what decibel levels he was exposed to during his career. There was no discussion of specific traumatic life events that occurred frequently in Petitioner's career. She acknowledged that Petitioner was not diagnosed with PTSD.

The legislature has recently enacted a new provision of the Illinois Workers' Compensation Act. Section 6(f) of the Act (820 ILCS 305/6(f) (West 2007)) creates among other things a rebuttable presumption that, after five years of service, a firefighter's heart disease or condition arises out of and in the course of his employment and that the same is causally related to his employment. The Commission finds that the application of this new provision of the Act presents a case of first impression. In applying the provision to the case at bar, the Commission turns to the Illinois Supreme Court and Appellate Court for guidance.

It has been recognized by the Courts that "[t]here is a good deal of confusion on [the] general proposition of what evidence, if any, overcomes a presumption, particularly a legislative one." *In re Marriage of Landfield,* 209 Ill. App. 3d 678, 691 (1991). The Illinois Supreme Court has explained:

> "The prevailing theory regarding presumptions that Illinois follows *** is Thayer's bursting-bubble hypothesis: once evidence is introduced contrary to the presumption, the bubble bursts and the presumption vanishes. (McCormick, Evidence sec. 345, at 821 (2d ed. 1972); see *Coal Creek Drainage & Levee District v. Sanitary District* (1929), 336 Ill. 11.) It is consistent with the Thayer approach that the party producing evidence to rebut the presumption must come forward with evidence that is 'sufficient to support a finding of the nonexistence of the presumed fact.' (Graham, Presumptions in Civil Cases in Illinois: Do They Exist? 1977 S. Ill. U. L.J. 1, 24.) ." *Franciscan Sisters Health Care Corp. v. Dean,* 95 Ill.2d 452, 462-63 (1983).

The Court continued:

> " '[O]nce evidence opposing the presumption comes into the case, the presumption ceases to operate, and the issue is determined on the basis of the evidence adduced at trial as if no presumption had ever existed. (See 1 Jones, Evidence sec. 3:8 (6th ed. 1972).) . The burden of proof thus does not shift but remains with the party who initially had the benefit of the presumption.' " *Franciscan Sisters,* 95 Ill.2d at 460-61, quoting *Diederich v. Walters*, 65 Ill. 2d 95, 100-03 (1976) .

Lastly,

> "The amount of evidence that is required from an adversary to meet the presumption is not determined by any fixed rule. A party may simply have to respond with some evidence or may have to respond with substantial evidence. If a strong presumption arises, the weight of the evidence brought in to rebut it must be great. 5 A.L.R.3d 19, 39 n.14 (1966)." *Franciscan*

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Sisters, 95 Ill.2d at 463; see also *In re Marriage of Landfield,* 209 Ill. App. 3d at 691-92.

With this framework in mind, the Commission now turns to the rebuttable presumption set forth in Section 6(f) of the Act. It bears emphasizing that this presumption is a legislative one. As such, it requires stronger evidence to overcome. Having reviewed all the evidence in the case at bar, the Commission finds that Respondent has successfully rebutted the presumption by providing strong evidence through its experts' opinions along with Petitioner's own health history, work history and Petitioner's own testimony to show there were other causes of Petitioner's cardiovascular problems and his condition is not related to his employment as a firefighter.

The presumption having successfully been rebutted, the Commission now weighs the evidence to determine whether Petitioner has met his burden of proving by a preponderance of the evidence that his heart attack was related to his employment with Respondent. The evidence in the case at bar shows as follows: at the time of the January 12, 2008 incident, Petitioner was at home. Petitioner had just finished physically exerting himself while cleaning his own personal garage. More specifically he testified he had swept, cleaned up material and moved a 50 pound bag of bird seed, either on a cart, through sliding it or through lifting it along with bags of fertilizer and wood. After he completed cleaning the garage, Petitioner was taking a shower at home when he initially felt chest pain that caused him to lie down. He was transported to the hospital where the cardiologist diagnosed a heart attack. At no time, did Petitioner indicate that he was "on-call", was wearing any fire fighter equipment, was listening to a fire fighter scanner or performing any other activity that connected him to his duties as an Assistant Fire Chief or a fire fighter in general. His activity of cleaning out his own garage was personal in nature.

During the last 1/3 of his career, Petitioner was working as an administrator/manager and was performing tasks that were more sedentary in nature and, with the exception of being "on-call" as a division chief every other month, he worked an 8 a.m.-5 p.m. schedule/40 hours a week. In terms of Petitioner's own physical shape it was shown that he had several cardiac risk factors in that he was male, overweight, on medications for both high blood pressure and cholesterol, of an advanced age, had a poor diet and family history of hypertension. The medical records indicate he had 80% stenosis in the mid right coronary, a 40-60% stenosis in the left artery and 40-50% stenosis in the left circumflex artery. In short he was "essentially a powder keg waiting to explode", as Dr. Fintel stated. The Commission finds that Dr. Fintel is better credentialed and possesses a greater foundational understanding of Petitioner's condition than Dr. Weaver. Additionally, his causation opinion is supported by the opinions of Drs. Scott and Ayers. As such, the Commission assigns greater weight to the causation opinions of Drs. Fintel, Scott and Ayers over those of Dr. Weaver. Accordingly, the Commission finds that Petitioner failed to meet his burden of proof. The Commission, therefore, finds that the case is not compensable.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's claim for compensation is hereby denied.

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

DATED: JAN 20 2015

MB/jm

O: 11/20/14
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Mario Basurto

Stephen Mathis

David L. Gore

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

PIOTR MILAN,

Petitioner,

vs.

NO: 09 WC 31957

INFINITY GROUP,

15IWCC0038

Respondent,

DECISION AND OPINION ON REVIEW

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

The Commission finds that the opinion of Dr. Sweeney is more persuasive than that of Respondent's Dr. Goldberg regarding the reasonableness and necessity of Petitioner undergoing a lumbar fusion. Dr. Goldberg recommended a second discogram prior to determining whether a fusion was indicated. Dr. Sweeney testified that the first discogram was a "red herring" and given Petitioner's objective pathology he wouldn't have even performed the first discogram. He testified that he is not basing his recommendation for lumbar fusion on the discogram and that, although he didn't object to a second discogram, the combination of Petitioner's objective testing and subjective complaints make him a surgical candidate without it. Dr. Sweeney did prescribe a new lumbar MRI prior to surgery.

We find that it is not reasonable or necessary to require Petitioner to undergo a second, invasive discogram when it is not being recommended by his treating physician, Dr. Sweeney.

We therefore modify the decision to specifically award the pre-operative MRI and lumbar fusion surgery as recommended by Dr. Sweeney without requiring the discogram.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $456.83 per week for a period of 255-4/7 weeks, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $236,840.15 for medical expenses under §8(a) of the Act subject to the fee schedule in §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall authorize and pay for prospective medical treatment recommended by Dr. Sweeney including the pre-operative MRI and lumbar fusion under §8(a) of the Act subject to the fee schedule in §8.2 of the Act.

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

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

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

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: JAN 20 2015

Charles J. DeVriendt

Daniel R. Donohoo

Ruth W. White

SE/
O: 12/17/14
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# ILLINOIS WORKERS' COMPENSATION COMMISSION
# NOTICE OF 19(b) DECISION OF ARBITRATOR
8(a)

MILAN, PIOTR
Employee/Petitioner

Case# **09WC031957**

INFINITY GROUP
Employer/Respondent

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On 2/3/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.06% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1315 DWORKIN & MACIARIELLO
DOMENIC MACIARIELLO
134 N LASALLE ST SUITE 1515
CHICAGO, IL 60602

0011 LAW OFFICES OF EDWARD J KOZEL
STEPHEN TROTTO
333 S WABASH AVE 25TH FL
CHICAGO, IL 60604

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STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

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

PIOTR MILAN
Employee/Petitioner

v.

INFINITY GROUP
Employer/Respondent

Case # **09** WC **31957**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the **Honorable Thompson-Smith**, Arbitrator of the Commission, in the city of **Chicago**, on **10-5-2011 and 11-7-2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

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FINDINGS

On 12-8-2008, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$35,632.48**; the average weekly wage was **$685.24**.

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

Petitioner ***has* not** received all reasonable and necessary medical services.

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

Respondent shall be given a credit of $ for TTD, **$24,512.74** for TPD, $ for maintenance, and $ for other benefits, for a total credit of **$24,512.74**.

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

ORDER

Respondent shall pay to Petitioner medical bills in the amount of $236,840 15, pursuant to Sections 8(a) and 8.2 of the Act. Respondent is not liable for the Medicaid lien in the amount of $10,633.26.

Respondent shall pay to Petitioner temporary total disability in the amount of $456.83 per week, for a period of 255 4/7 weeks beginning December 9, 2008 through November 7, 2013.

Respondent shall pay for diagnostic testing as recommended by Dr. Sweeney and if said tests indicate that the Petitioner is in need of further surgery, said surgery and rehabilitative services shall be authorized and paid for by Respondent.

Respondent shall have a credit in the amount of $24,512.74, for temporary total disability payment previously paid to Petitioner.

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

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

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FINDINGS OF FACT

The disputed issues in this matter are: 1) causal connection; 2) medical bills; 3) temporary total disability ("TTD"); and prospective medical treatment. *See,* Ax1.

Petitioner, a 52-year-old trailer mechanic, testified at arbitration that on December 8, 2008, while he was fixing a trailer tire at work, he slipped and had a sudden pain in his left leg and spine (T 14-16). The next day the Petitioner continued to have a "terrible pain in his back" so he called his boss who told him to go to Concentra Clinic (T-17).

On December 9, 2008, Petitioner went to Concentra Medical Center, ("Concentra") where he gave a history through a polish translator that on December 8, 2008, "I was putting a tire on truck and as I pick it up I felt something pull my back". Petitioner complained of pain on the right mid-back and lower back radiating to the left leg. Petitioner also complained of numbness in both hands; however, there are no subjective complaints of pain or trauma noted to the neck. After examination, the initial diagnosis was thoracic and lumbar strain. Petitioner was placed on light duty, prescribed physical therapy; and instructed to follow-up on December 11, 2008. *See,* PX1.

On December 11, 2008, Petitioner returned to Concentra where he afforded a history of no improvement with the pain located on the right mid and lower back. Again, Petitioner did not complain of pain or trauma to the neck. Concentra records reflect that as protocol, a full physical examination, which included the neck, was performed. At that time, Petitioner's neck had full range of motion, no probable bony or muscular tenderness and negative spurling and axial load. After examination, the diagnosis was thoracic and lumbar strain. Petitioner was continued on light duty and physical therapy.

On December 18, 2008, Petitioner returned to Concentra and complained of pain located in the lower and mid back. It was also noted that the pain radiated down the back to the left leg. The Arbitrator notes that there continues to be no subjective complaints of pain or trauma to the neck documented in the medical records, to this date.

On December 22, and 26, 2008, Petitioner continued to receive physical therapy at Concentra. The Arbitrator further notes that Petitioner continued to complain of pain to the lumbar and thoracic region but did not complain of cervical pain or bilateral hand numbness.

On January 5, 2009, Petitioner presented to Dr. Gaces at Concentra who noted continued pain in the lower and mid back. Dr. Gaces performed a complete examination of the petitioner's musculoskeletal structure, including the cervical region. Examination of the neck revealed full range of motion, no tenderness, no swelling and no pain on motion. *See,* PX1.

On January 14, 2009, Petitioner underwent an MRI of the lumbar and thoracic spine, which revealed multi-level thoracolumbar degenerative disc disease and facet arthropathy, with associated central spinal canal stenosis, neural foraminal narrowing and mass effect upon nerve roots.

On January 28, 2009, Dr. Cerullo noticed that Petitioner was complaining of pain in his low back, numbness in his left leg but now also numbness in his hands, which had not been previously investigated. He ordered an MRI of the cervical spine, which demonstrated protrusions at C3-4, C4-5 and C6-7. There was also a bulge at C5-6. Although an EMG/NCV came back as showing normal results in March of 2009, a discogram performed in May of 2009, was interpreted as showing posterior, annular tears at L3-4 through S1; with protrusions at those levels and bulges at L1-2 and L2-3. Petitioner wanted to seek a second opinion regarding surgery. After examination, Dr. Cerullo prescribed an MRI of the cervical spine and a epidural steroid injection at L4-5 on the left.

On February 16, 2009, Petitioner underwent a MRI scan at Advantage MRI which was read as straightening of the normal cervical lordosis; and multi-level disc desiccation changes, more pronounced at C3-C4 and C6-C7.

On March 20, 2009, Dr. Heller performed an EMG/NCV of Petitioner's lower and upper extremities. Dr. Heller noted a history of low back pain radiating into the left anterior thigh. Dr. Heller also noted numbness in Petitioner's fingers and hands. However, Dr. Heller noted that Petitioner denied any numbness radiating more proximally, denies arm pain, and denies neck pain. His impression was a normal cervical and lumbar EMG/NCV accept for mild swelling of the ulnar sensory nerves bilaterally most probably consistent with mild swelling at the Guyons canal bilaterally.

On May 4, 2009, Petitioner underwent a discogram with only "fair validity". However, the post discogram MRI scan impression was posterior annular tears and protrusion at L3-4 through L5-S1. On May 6, 2009, Dr. Cerullo suggested that surgery may be necessary, consisting of a four level lumbar fusion. Dr. Cerullo noted that Petitioner was reluctant to undergo surgery at that time. *See*, PX2.

On December 17, 2009, Petitioner came under the care of Dr. Patrick J. Sweeney who noted lumbar and cervical pain due to the accident of December 8, 2008. Dr. Sweeney reviewed the MRI films of the neck and lumbar spine. According to Dr. Sweeney, the films revealed herniated disc at C3-4 and C6-7 and C5-6 autofusion. MRI of the lumbar spine revealed L4-5 and L5-S1 central herniation; foraminal stenosis at L4-5; bulging disc at L3-4 more than L2-3. *See,* PX6, pgs. 7-10.

Because Dr. Sweeney was not satisfied with the quality of the first set of films, he performed repeat MRIs of the cervical and lumbar spine which revealed C3-4, C4-5, C6-7 significant disc herniations with significant spinal cord compression. MRI of the lumbar spine revealed multi-level degenerative disc disease, but L4-5 particularly had pathology with bulging versus herniation and significant foraminal stenosis left greater than the right. Dr. Sweeney stated in his deposition that the L4-5 was probably causing most of Petitioner's pain of the left lower extremity and low back problems. However, according to Dr. Sweeney, Petitioner's cervical problem was so severe that it needed to be addressed surgically, before he did anything with the lower back. Dr. Sweeney stated that the cervical surgery was denied so he advised Petitioner to "get on Medicaid [and] he would probably get the surgery done". On February 15, 2011, Dr. Sweeney performed C3-4, C4-5, C6-7 cervical fusion because the petitioner was in so much pain and he perceived the that the cervical problem was severe enough that it needed to be addressed surgically prior to the lumbar problem. He also stated that Petitioner had pre-existing cervical arthritis, but that it was asymptomatic prior to his injury. *See*, PX3, pgs. 13-20 & PX6 pgs. 14-18.

On April 18, 2011, Dr. Goldberg testified by deposition that he did not feel there was a cervical spine injury at the time of accident on December 8, 2008, based on his review of the medical records. Dr. Goldberg testified that according to the medical records from Concentra Medical Center, Petitioner did not complain of neck pain at the time of accident. Dr. Goldberg did testify that at the time of accident Petitioner sustained injury to the thoracic and lumbar spine. *See,* RX9, pgs. 8-9.

On July 8, 2009, Petitioner underwent a functional capacity evaluation ("FCE") evaluation at Accelerated Rehabilitation. On September 18, 2009, Petitioner was again examined by Dr. Goldberg, who found diminished sensation in the C5 to T1 and L3 to D1 in the upper and lower extremities however, he did not examine the thoracic area. Dr. Goldberg stated that this was not anatomically possible. Dr. Goldberg further stated that based on the FCE and his examination Petitioner could return to work without restrictions.

On April 18, 2011, Dr. Goldberg testified that the original discogram was incomplete because it did not include normal levels and recommended the possibility of an additional discogram by an independent physician. Dr. Goldberg stated that after Petitioner underwent the discogram he would then recommend whether Petitioner should undergo a lumbar fusion. PX7 pgs. 14-15; Tr. 13-15 & RX4.

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Conclusions of Law

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

The claimant has the burden of proving, by a preponderance of the evidence, all of the elements of her claim. It is the function of the Commission to judge the credibility of the witnesses and resolve conflicts in medical evidence. *See, O'Dette v. Industrial Comm'n*, 79 Ill. 2d. 249, 253, 403 N.E.2d 221, 223 (1980). In deciding questions of fact, it is the function of the Commission to resolve conflicting medical evidence, judge the credibility of the witnesses and assign weight to the witnesses' testimony. *See, R & D Thiel*, 398 Ill. App.3d at 868; *See also, Hosteny v. Workers' Compensation Comm'n*, 397 Ill. App. 3d 665, 674 (2009).

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

It is within the province of the Commission to determine the factual issues, to decide the weight to be given to the evidence and the reasonable inferences to be drawn there from; and to assess the credibility of witnesses. *See, Marathon Oil Co. v. Industrial Comm'n*, 203 Ill. App. 3d 809, 815-16 (1990). And it is the province of the Commission to decide questions of fact and causation; to judge the credibility of witnesses and to resolve conflicting medical evidence. *See, Steve Foley Cadillac v. Industrial Comm'n*, 283 Ill. App. 3d 607, 610 (1998).

It is established law that at hearing, it is the employee's burden to establish the elements of his claim by a preponderance of credible evidence. *See, Illinois Bell Tel. Co. v. Industrial Comm'n.*, 265 Ill. App. 3d 681; 638 N.E. 2d 307 (1st Dist. 1994). This includes the issue of whether Petitioner's current state of ill-being is causally related to the alleged work accident. *Id.* A claimant must prove causal connection by evidence from which inferences can be fairly and reasonably drawn. *See, Caterpillar Tractor Co. v. Industrial Comm'n.*, 83 Ill. 2d 213; 414 N.E. 2d 740 (1980). Also, causal connection can be inferred. Proof of an employee's state of good health prior to the time of injury and the change immediately following the injury is competent as tending to establish that the impaired condition was due to the injury. *See, Westinghouse Electric Co. v. Industrial Comm'n*, 64 Ill. 2d 244, 356 N.E.2d 28 (1976). Furthermore, a causal connection between work duties and a condition may be established by a chain of events including Petitioner's ability to perform the duties before the date of the accident and inability to perform the same duties following that date. *See, Darling v. Industrial Comm'n*, 176 Ill.App.3d 186, 193 (1986).

The Arbitrator finds the opinions of Dr. Sweeney to be more persuasive than those of Dr. Goldberg and that the Petitioner's present condition of ill-being is causally related to the accident of December 8, 2008.

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

Based on the above findings, the Arbitrator finds that Petitioner has proven, by a preponderance of the evidence, that a causal relationship exists between his present condition of ill-being and the accidental injury sustained on December 8, 2008. Therefore, Respondent shall pay to Petitioner all medical bills due, as referenced in Petitioner's Exhibit 8, pursuant to Sections 8(a) and 8.2 of the Act. Respondent has no responsibility to pay the lien from the Illinois Department of Human Services, in the amount of $10,633.26.

K. Is Petitioner entitled to any prospective medical care?

The Arbitrator finds that Petitioner's lumbar condition is causally related to said accidental injuries and mandates that Respondent authorize a discogram as recommended by Dr. Goldberg. The lumbar fusion as recommended by Dr. Sweeney will be stayed until findings of the discogram are reviewed and a determination is made as to the necessity of said surgery. If diagnostic testing confirms that the petitioner is in need of further surgery, Respondent shall authorize and pay for said surgery.

L. What temporary benefits are in dispute?

Respondent shall pay Petitioner TTD benefits from December 8, 2008 through November 7, 2013.

15IWCC0038

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
09WC31957
SIGNATURE PAGE

Signature of Arbitrator

February 3, 2014
Date of Decision

FEB 3 - 2014

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

RAY STONE,

Petitioner,

vs.

NO: 08 WC 11072

DEKALB DRAFTING & DESIGN,

15IWCC0039

Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent and Petitioner herein and notice given to all parties, the Commission, after considering the issues of causation, temporary total disability, medical expenses, benefit/wage rate, penalties, attorney's fees, and "1% interest on unpaid 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 notes that Petitioner was found to be at maximum medical improvement for his neck by Dr. Bauer on June 8, 2012 and was given permanent 25-pound lifting restrictions. Since Petitioner's condition had stabilized, he is not entitled to temporary total disability after that date. However, we find that he is entitled to maintenance under Section 8(a) beginning June 9, 2012, since he was unable to return to his previous occupation. Petitioner testified that he has undergone a self-directed job search without any success and introduced his job search logs (Px13).

The Commission hereby modifies the decision to award temporary total disability benefits from June 21, 2007 through January 5, 2009 and April 28, 2010 through June 8, 2012

for a total of 191-1/7 weeks. Petitioner is also entitled to 66-5/7 weeks of maintenance benefits for the period from June 9, 2012 through September 18, 2013.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $780.97 per week for a period of 191-1/7 weeks, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $780.97 per week for a period of 66-5/7 weeks, that being the period of maintenance under §8(a) of the Act, 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 maintenance or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $135,762.57 for medical expenses under §8(a) of the Act subject to the medical fee schedule in §8.2 of the Act.

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

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

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

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: JAN 20 2015

Charles J. DeVriendt

Daniel R. Donohoo

Ruth W. White

SE/
O: 12/17/14
49

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

STONE, RAY
Employee/Petitioner

Case# **08WC011072**

15IWCC0039

DeKALB DRAFTING & DESIGN
Employer/Respondent

On 12/30/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.09% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0274 HORWITZ HORWITZ & ASSOC LTD
TYLER BERBERICH
25 E WASHINGTON ST SUITE 900
CHICAGO, IL 60602

0445 RODDY LEAHY GUILL & ZIMA LTD
SAM CERNIGLIA
303 W MADISON ST SUITE 1500
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)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Ray Stone
Employee/Petitioner

v.

DeKalb Drafting & Design
Employer/Respondent

15IWCC0039

Case # 08 WC 11072

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 **New Lenox**, on **September 18, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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 20, 2007**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$60,915.40**; the average weekly wage was **$1,171.45**.

On the date of accident, Petitioner was **40** 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 **$151,997.02** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$151,997.02**.

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 $780.97/week for 257.85 weeks, commencing June 21, 2007 through January 5, 2009 and April 28, 2010 through September 18, 2013, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services of $135,762.57, as provided in Sections 8(a) and 8.2 of the Act. This amount has been calculated by the Arbitrator and found to be the fee schedule amount due.

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

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

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

Signature of Arbitrator — 12/27/13 Date

ICArbDec19(b)

DEC 30 2013

STATEMENT OF FACTS

On June 20, 2007, Petitioner, Ray Stone, was employed by Respondent, DeKalb Drafting & Design as a field service technician. As a technician, Petitioner performed various physical tasks such as welding, bending pipes, as well as lifting bundles of pipes and other objects which could weigh from 75 to 125 pounds.

On June 20, 2007, Petitioner was working at a job site in Texas for Respondent. As part of his job duties that day, Petitioner was climbing a ladder to the top of a large press. When Petitioner had reached a point on the ladder about 14 feet above ground level, the bottom of the ladder kicked out from under him and he fell to the ground, along with the ladder. Petitioner testified that as he fell, his right arm held the ladder and his left arm pushed through the rungs of the ladder. Petitioner testified that after the fall, he noticed extreme pain in his left arm.

Petitioner was immediately taken to the emergency room at Valley Regional Medical Center. There, the Petitioner was diagnosed with a comminuted fracture of the distal radius and a Colles fracture in the left wrist. Petitioner was further diagnosed with a right ankle sprain. Petitioner was prescribed Vicodin for pain control and instructed to follow up with a physician upon his return to Illinois. (PX 9)

On June 21, 2007, Petitioner followed up with Dr. Richard Boyd at Porter Memorial Hospital. Dr. Boyd detailed Petitioner's accident history and referred Petitioner to follow up with an orthopedic physician. (PX 10)

On June 22, 2007, Petitioner saw Dr. Anthony Levenda, an orthopedic physician at Lakeshore Bone and Joint Institute. Petitioner complained of continued left wrist and right foot pain, with tingling into the tips of his fingers. Dr. Levenda recommended surgical repair of the left wrist and ordered Petitioner off work. (PX 4)

On June 27, 2007, Petitioner underwent an open reduction and internal fixation with volar plating in the left wrist. Petitioner's pre and post-operative diagnosis was left distal radius fracture, inraarticular, comminuted. This surgery was performed by Dr. Levenda. (PX 6)

On June 28, 2007, due to swelling and pain after surgery, Dr. Levenda ordered a prescription of Percocet for Petitioner. (PX 4)

Petitioner followed-up with Dr. Levenda on July 5, 2007. Petitioner's wrist was re-splinted and Petitioner was placed on a work status of no use of the left upper extremity. (PX 4) Petitioner testified that he was not offered any work within that restriction.

Petitioner began post-surgical therapy for his left wrist on July 12, 2007, also at Lakeshore Bone and Joint Institute. (PX 4)

On July 30, 2007, Petitioner followed up with Dr. Levenda who noted that Petitioner was having occasional shooting pain in the dorsoulnar aspect of his left hand. Petitioner was kept on the same work restrictions as previously ordered. Dr. Levenda also recommended continued physical therapy. (PX 4)

On August 23, 2007, Petitioner again saw Dr. Levenda. At that time, Petitioner continued complaining of left wrist pain on rotation. Petitioner also complained of right shoulder pain with some pain radiating down his arm. At that time, Petitioner informed Dr. Levenda that his right shoulder pain had been present since the accident, but that he had previously been more worried about his left wrist. Petitioner reported that he had experienced

difficulty sleeping at night and with any overhead actives. Dr. Levenda recommended that Petitioner begin formal therapy for the right shoulder. Dr. Levenda also administered a Cortisone injection into Petitioner's right shoulder. Petitioner was placed on an off work status. (PX 4)

On September 11, 2007, Dr. Levenda diagnosed Petitioner with status post open reduction and internal fixation to the left wrist, and type II acromion with impingement of the right shoulder. Due to continued complaints of shoulder pain, he was referred to continued physical therapy. Petitioner was placed on a 10 pound lifting restriction with the left wrist. (PX 4)

Petitioner continued physical therapy and continued to follow up with Dr. Levenda into November of 2007. On November 29, 2007, Dr. Levenda noted that Petitioner's right shoulder symptoms were improved, but that certain activities bothered him. Petitioner was also having pain in his left wrist with work activities. A CT scan was ordered of the left wrist and a Cortisone injection was performed on the right shoulder. The doctor noted that if there was no improvement with injection, surgery was a possibility. (PX 4)

In December 2007 and January 2008, Petitioner continued to follow up with Dr. Levenda, with continued complaints of left wrist pain on the ulnar side and right shoulder pain with activities. On January 31, 2008, Dr. Levenda recommended a second opinion for Petitioner's continuing left wrist symptoms with Dr. Anderson and recommended surgery for the right shoulder. (PX 4)

On February 13, 2008, Petitioner was seen by Dr. Aaron Anderson. The doctor diagnosed Petitioner with a failed open reduction and internal fixation in the left wrist. He further diagnosed ulnar abutment syndrome as well as questionable non-union of the distal ulna. Dr. Anderson ordered a CT scan of the left wrist. (PX 4)

On February 25, 2008, Petitioner was seen again by Dr. Anderson. Dr. Anderson reviewed Petitioner's left wrist CT scan from February 18, 2008 and recommended a left distal radius open reduction and internal fixation to repair failed hardware in the joint and a significant amount of shortening with positive variance of his distal ulna. (PX 4)

On March 13, 2008, Petitioner underwent an ulnar shortening and deep hardware removal in his left wrist. The surgery was performed by Dr. Anderson with pre and post-operative diagnoses of painful hardware and ulnar abutment syndrome, status post distal radius fracture. (PX 6)

On March 17, 2008, Petitioner was seen in follow up by Dr. Anderson. Petitioner was referred to begin physical therapy for the left wrist and did begin therapy that day. He was placed on restrictions including no use of the left upper extremity. (PX 4)

On April 11, 2008, Petitioner returned to Dr. Anderson. Petitioner was having increased left side wrist pain. X-rays were performed which showed good healing in the radius, but that a screw had backed out of the wrist plate. Dr. Anderson recommended surgical removal of the screw. (PX 4)

On April 22, 2008, Petitioner underwent a surgical procedure to remove the screw from the left wrist hardware and perform an open reduction and internal fixation of the left wrist. This procedure was performed by Dr. Anderson. (PX 6)

Petitioner continued to follow up with Dr. Anderson through August of 2008 for his left wrist. On August 6, 2008, Dr. Anderson noted that Petitioner still had pain in the wrist with pushing and lifting, as well as upon direct pressure to the wrist. Dr. Anderson opined that Petitioner had reached maximum medical improvement for the left wrist at that time. (PX 4)

On August 18, 2008, Petitioner again saw Dr. Anderson for his right shoulder pain. Dr. Anderson noted that Petitioner had been previously treated conservatively for his right shoulder pain, but that treatment had failed. At that time, he recommended surgery. (PX 4)

On September 24, 2008, Dr. Anderson drafted a note stating that Petitioner's surgery had been denied for the right shoulder, claiming that Petitioner had not had conservative management first. Dr. Anderson noted that Petitioner had been treated with 8 total injections, 2 months of formal therapy and 10 months of therapy on his own prior to being referred to his office for care. (PX 4)

On October 28, 2008, Petitioner underwent a right shoulder arthroscopy with debridement of degenerative SLAP tear, acromioplasty and distal clavicle excision. This surgery was performed by Dr. Anderson with pre and post-operative diagnoses of right shoulder impingement syndrome, right shoulder AC joint arthritis and right shoulder degenerative SLAP tear. (PX 10)

Following surgery, Petitioner followed up with Dr. Anderson and performed physical therapy into January of 2009. On January 5, 2009, Petitioner was cleared by Dr. Anderson to return to work at full duty. (PX 4)

Petitioner testified that upon his release to return to full duty, he was advised by Respondent that no work was available. As a result he attempted to find work. Petitioner provided that his shoulder got progressively worse and he continued with wrist pain.

On February 12, 2010, Petitioner returned to Dr. Anderson complaining mostly of pain in his left wrist with extension or flexion, as well as with any pounding-type activities. Dr. Anderson diagnosed Petitioner with degenerative arthritis from work-related injury, causing increasing pain with heavy activities. Dr. Anderson recommended that a different line of work would probably be in Petitioner's best interest over the long term and that the condition of his left wrist would only get worse with repetitive heavy motion. (PX 4)

On April 28, 2010, Dr. Anderson noted that Petitioner had continued left wrist pain and discomfort with motion. He also noted that Petitioner had decreased left hand strength and pain after working. Dr. Anderson stated "Recommendation for patient would be to find another line of work that only requires lighter-duty type activities. As stated previously, heavy activity and repetitive heavy motion, would cause exacerbation of arthritic symptoms. Unrestricted duty in a career conducive to light activity would be recommended and encouraged for relief of long-term arthritis management." (PX 4)

On September 23, 2010, a Functional Capacity Evaluation was ordered for Petitioner by Lakeshore Bone and Joint Institute.

On October 13, 2010, Petitioner underwent a FCE at ATI Physical Therapy. The FCE results indicate that Petitioner was capable of working at a medium to heavy physical demand level, occasionally lifting up to 75 pounds and frequently lifting up to 35 pounds. (PX 3) Petitioner testified that during the FCE the pain in his right shoulder increased dramatically. Petitioner provided that he experienced shocks into his right shoulder when trying to carry weights. The shocks would run from the back of his neck, down his shoulder and right arm, into the fingertips of his right hand. Petitioner stated that after the exam, his right arm hurt "tremendously" and he experienced extreme pain. The FCE record from ATI records that Petitioner experienced electric shock type pain on numerous occasions in his hand, fingers, forearm and elbow, as well as experiencing pain into his right shoulder repeatedly. (PX 3)

At Respondent's request, Petitioner was seen in a Section 12 Examination by Dr. Prasant Atluri on November 8, 2010. Dr. Atluri recorded a history of Petitioner's work accident on June 20, 2007, which initially caused pain and swelling in Petitioner's right shoulder, left hand and left ankle. He noted the treatment and

surgery to Petitioner's left wrist, as well as the current condition of Petitioner's left wrist. Petitioner reported that he had continued pain in his left wrist with pain into the forearm, radiating into the fingers of his left hand with gripping. Petitioner also complained of aching in the right shoulder and some neck pain. Dr. Atluri performed a physical examination which revealed, among other things, a positive Spurling's sign on the right along with tenderness on the right side of the neck. Dr. Atluri's impression included 1) left wrist post-traumatic arthritis, 2) comminuted intra-articular distal radius fracture, status post ORIF, ulnar shortening osteotomy with revision, internal fixation, partial hardware removal, 3) left distal radius mal-union, 4) right shoulder pain, status post right shoulder arthroscopy, and 5) possible cervical radiculopathy, right upper extremity. Dr. Atluri opined that the "on-going and progressively worsening symptoms in this patient's left wrist would be considered a combination of the deformity, malunion and post traumatic arthrosis from his injury from May of 2007 as well as any forceful or heavy use of his left hand and wrist subsequent to that injury which may have aggravated his condition." (RX 1)

On January 15, 2011, Petitioner was seen in the Porter Memorial Hospital emergency room. At that time, Petitioner complained of extreme pain in the back of his neck and right shoulder, going down the right arm that had begun after an FCE in November. (PX 10) Petitioner testified that the pain that lead him to the emergency room was the same pattern of pain he experienced during his FCE. (PX 10)

On March 17, 2011, Petitioner was seen by Dr. Jerrell Boyer at Swedish Covenant Hospital. Petitioner complained of pain in his right arm with burning and numbness and weakness in the right hand. He had neck and shoulder pain. Dr. Boyer diagnosed Petitioner with cervical disc herniation, cervical radiculitis and cervical degenerative disc disease. (PX 1)

On March 24, 2011, Petitioner underwent a cervical spine CT scan, ordered by Dr. Boyer. The scan revealed bulging disc or disc protrusion from the level of C3-C7 in addition to hypertrophic change. The resultant spinal stenosis was considered worse at C5-6 and C6-7. (PX 1)

On March 31, 2011, Petitioner returned to Dr. Boyer. The doctor recommended cervical discectomy and fusion at C5-6 and C6-7. He further opined that Petitioner's "symptoms were present since the time of his accident per the history; therefore his imaging studies and radiculopathy are causally related to his occupational injury." (PX 1)

On May 4, 2011, Petitioner underwent a C5-6, C6-7 cervical discectomy with instrumentation. Petitioner's surgery was performed by Dr. Boyer with a pre and post-operative diagnosis of cervical pain, cervical degenerative disc disease with severe foraminal stenosis at C5-6, C6-7, bilateral upper extremity radiculopathy. (PX 5)

Petitioner followed up with Dr. Boyer post-operatively through October of 2011, when he began physical therapy at Maximum Rehabilitation. (PX 7) During that time, Petitioner's shoulder pain and neck pain improved. (PX 1)

At Respondent's request, Petitioner was seen for a respondent's Section 12 examination with Dr. Jerry Bauer on November 7, 2011. Dr. Bauer opined that there was no indication that Petitioner sustained an injury to his neck or cervical radiculopathy subsequent to his June 20, 2007 work accident. He further opined that the need for fusion surgery was caused by the underlying degenerative changes in Petitioner's cervical spine. (RX 2)

On November 17, 2011, Petitioner was seen again by Dr. Boyer. Dr. Boyer recommended that Petitioner continued physical therapy. Dr. Boyer further opined that "I think at this point we should consider some vocational rehabilitation for this gentleman as he will not be able to return to his former level of employment." (PX 1)

At his request, Petitioner underwent an Independent Medical Evaluation by Dr. Cary Templin, a spinal surgeon at Hinsdale Orthopaedics, on March 3, 2012. Dr. Templin opined that the current condition of Petitioner's cervical spine was causally related to his June 20, 2007 work accident. Dr. Templin explained that such a violent fall from a ladder can cause an aggravation of cervical spondylosis, "as when there is underlying foraminal stenosis, although his complaints initially waxed and waned, as we see from his initial complaints of 08/2007, where he had pain and on multiple occasions noted pain to the region, there also likely was some aspect of the shoulder pain related to this pain emanating from his neck. This was then further aggravated by the functional capacity evaluation, lifting objects weighing over 80 pounds on multiple occasions, at which time he did make complaints of pain to both the right than the left extremities, and then he had continual decline after the second aggravation of this injury." (PX 11)

On June 8, 2012, Petitioner returned to Dr. Boyer. The doctor opined that Petitioner had reached maximum medical improvement and could return to work with a permanent restriction of no lifting greater than 25 pounds due to the condition of his cervical spine. (PX 1)

At trial on this matter, Petitioner testified that he continues to experience constant pain in the left wrist. Petitioner provided that he has lost dexterity in the left wrist and cannot turn anything with the fingers of that hand. His left hand falls asleep, cramps and aches when he attempts twisting maneuvers with his left wrist. Petitioner testified that he is not experiencing specific pain in his neck and that his right shoulder pain was alleviated by surgery.

Petitioner explained that he experienced right shoulder pain from June 20, 2007 through May 4, 2011. Petitioner indicated that his shoulder pain decreased some following his shoulder surgery, but it returned. His right shoulder and neck pain were severely worsened during his FCE. Only after the May 4, 2011 cervical fusion, performed by Dr. Boyer, was his right shoulder pain alleviated.

Petitioner testified that Respondent has never offered rehabilitation assistance to him. After being released with permanent restrictions, he has performed a self-directed job search. He has applied for a significant number of jobs, as outlined in the job search logs contained in petitioner's exhibit 13. Petitioner stated he has received no job offers during his search.

Petitioner testified that he has also spent his time studying and trying to learn online. He has recently been studying for his CDL license. Petitioner also testified that he has sustained no new injuries to his left wrist, right shoulder or cervical spine other than during his June 20, 2007 accident and October 13, 2010 FCE. Petitioner also reviewed the pay records contained in Petitioner's Exhibit 14. Petitioner testified that those pay records were accurate. He further testified that he worked 5 day work weeks, 8 hours per day. Any weekend work or work over 8 hours in a day would constitute overtime. Petitioner further testified that overtime was mandatory indicating, "...jobs [were] based on get[ting] the job done."

Deposition Testimony of Dr. Cary Templin – November 2, 2012

Dr. Templin is an orthopedic surgeon, who is a spinal surgeon, who performed a Section 12 exam at the request of Petitioner on February 28, 2012. (PX 12 @ 3-5)

When Petitioner was seen by Dr. Templin, he provided a history of falling from a ladder at work, injuring his left wrist and causing pain in his right shoulder. (PX 12 @ 7)

After reviewing Petitioner's medical history and performing an examination, Dr. Templin opined that Petitioner had sustained multiple traumatic injuries from his work accident. He noted that though Petitioner's neck

complaints were not severe, over time the complaints worsened, Petitioner was treated appropriately for his cervical spine and he was doing quite well. (PX 12 @ 9)

Dr. Templin specifically cited Dr. Atluri's Section 12 report, which details Petitioner's worsening neck pain after his October 2010 FCE. (PX 12 @ 10) Dr. Templin further reviewed the January 15, 2011 report from Porter Hospital in which Petitioner complained of intolerable right neck and shoulder pain, with tingling into the right arm that started during his October 2010 FCE. (PX 12 @ 11)

Dr. Templin diagnosed Petitioner with cervical radiculopathy and cervical spondylosis which had responded well to surgery. (PX 12 @ 12)

Dr. Templin opined that the condition of Petitioner's cervical spine was causally related to his June 20, 2007 work accident. Dr. Templin's opinion was two-fold. He explained that Petitioner initially had some complaints to the right shoulder region, which could have been manifestations of radiculopathy from the neck and, after the FCE, Petitioner had more significant pain to the right arm. The doctor stated it appeared as though the FCE further aggravated his condition. (PX 12 @ 12-13)

Additionlly, Dr. Templin opined that the need for Petitioner's cervical fusion was, more likely than not, causally related to his June 20, 2007 fall; explaining that the fall and the activities of the FCE aggravated the underlying degenerative condition in his cervical spine. Dr. Templin specifically referred to the "electric shock type pain" experienced by Petitioner during his FCE, indicating possible radiculopathy. (PX 12 @ 14)

Cross-Examination

Dr. Templin explained that Petitioner did not report that he had posterior neck pain at the time of his original injury but that he did have right shoulder pain. (PX 12 @ 16-17)

Dr. Templin further stated that Petitioner could have herniated a disc at the time of the injury and not had radicular complaints right away if it was not hitting a nerve root. Or, Petitioner's severely broken wrist and pain medication for that broken wrist could have masked the symptoms of the cervical injury. (PX 12 @ 17)

When asked when did Petitioner began complaining of neck pain, Dr. Templin again explained that Petitioner was complaining of pain in the right shoulder all along, which certainly could have been coming from the neck or at least have been contributed to by the neck. (PX 12 @ 19) Again, when asked about Petitioner's pain during the FCE, Dr. Templin explained that he felt that Petitioner's right shoulder pain was related to the neck and pointed out that Petitioner responded well to neck surgery which took away the shoulder pain. (PX 12 @ 20)

Dr. Templin summarized his opinion in reviewing Dr. Atluri's IME report and explaining, "I think that what is important is that the patient notes shoulder pain, continued shoulder pain. He had shoulder pain in August of 2007, he's had shoulder pain all along, and he underwent a shoulder surgery that really didn't do much for him. In this note here, he continues to have shoulder pain. He notes shoulder pain during his FCE. He then develops severe shoulder, neck, and arm pain, has surgery for it, and it all gets better." (PX 12 @ 22)

When asked about Petitioner's reports of shoulder or neck pain after the FCE, Dr. Templin explained, "I think he's had shoulder pain all along and it got aggravated, and certainly, symptoms wax and wane. So if he has severe symptoms during exertion with a Functional Capacity Evaluation, things can get better, and he may not complain of them every day, and then they get to a breaking point, where he was when he went to the ER." (PX 12 @ 26)

Dr. Templin further pointed out that Petitioner had an extremely bad wrist injury that may have led him away from cervical and shoulder complaints right after the accident. However, when the wrist injury died down, in August, Petitioner began complaining of right-sided neck and shoulder pain. (PX 12 @ 27-28)

Dr. Templin also testified that trauma can cause degeneration of a disc. Then, if the disc continues to degenerate over a three year period and becomes more symptomatic, after which a person goes through an exertional test, they can get manifestation of symptoms with radiculopathy. (PX 12 @ 29)

Re-Direct Examination

Dr. Templin explained that Dr. Atluri had also found a positive Spurling's sign during his IME, which can be indicative of radiculopathy, leading Dr. Atluri to also diagnose possible radiculopathy. (PX 12 @ 32-33)

Deposition Testimony of Dr. Jerry Bauer – April 17, 2013

Direct Examination

Dr. Bauer is a board certified neurosurgeon who performed a Section 12 examination on November 7, 2011 at the request of Respondent. (RX 3 @ 3-4)

Dr. Bauer testified that he was given a history of Petitioner falling from a ladder on June 20, 2011, receiving treatment at the emergency room, then treating with Dr. Levenda. Dr. Bauer reviewed Petitioner's treatment and surgery for his left wrist, some treatment for his right shoulder and complaints of radicular pain down his arms. (RX 3 @ 5-6)

At the time of his November 7, 2011 examination, Petitioner told Dr. Bauer that he had severe radicular pain in his right arm and neck, which began after his October 13, 2010 FCE. (RX 3 @ 7) Dr. Bauer testified that Petitioner connected his cervical condition to the October 13, 2010 FCE, but testified that he reviewed the FCE and felt that it did not reveal any cervical injury. The doctor provided that had Petitioner injured his cervical spine on June 20, 2007, he would have expected complaints of cervical pain that day or shortly thereafter. (RX 3 @ 9)

Regarding Petitioner's first complaints of right shoulder pain in the records, Dr. Bauer testified that because he didn't see any symptoms or complaints in Dr. Levenda's records after August 23, 2007 that would suggest a pinched nerve in Petitioner's neck, it was hard to know whether Petitioner's complaints of shoulder pain and radiation on August 23, 2007 was of significance. (RX 3 @ 9) Dr. Bauer also stated that because there is no mention of neck pain in the August 23, 2007 note, saying it was a pinched nerve would be speculative. (RX 3 @ 10)

Dr. Bauer opined that the condition of Petitioner's right shoulder would have been temporary as of August 23, 2007, because he believed that there was no mention of that type of pain in Dr. Levenda's notes after that date and there was no mention of a cervical injury during the FCE. (RX 3 @ 10-11)

Dr. Bauer disagreed that Petitioner's wrist and shoulder injuries could have masked his cervical injury. He stated that he would expect Petitioner to be able to differentiate the wrist injury and pain down his arm, because it's different pain. (RX 3 @ 13)

Dr. Bauer found all findings on Petitioner's MRI and CT scans to have been degenerative in nature. (RX 3 @ 13) He further opined that had those conditions been aggravated, Petitioner would have complained of cervical symptoms on or soon after June 20, 2007. (RX 3 @ 14)

Dr. Bauer opined that Petitioner's cervical condition was not related to his June 20, 2007 work injury. He testified that Petitioner did not complain of neck or arm pain after the June 20, 2007 fall and claimed that Petitioner told him his symptoms began on October 13, 2010 during the FCE. He further claimed that Petitioner had no cervical complaints to Dr. Atluri or Dr. Aribindi during their IMEs in late 2010. Not until January 15, 2011 did Dr. Bauer believe Petitioner made complaints of cervical symptoms. (RX 3 @ 16)

Cross-Examination

Dr. Bauer testified that he did review the FCE but he did not detail its contents because he believed the outcome of the FCE was due to the condition of Petitioner's wrist and he was not examining Petitioner's wrist. Dr. Bauer did not think Petitioner made any note of injury during the FCE. (RX 3 @ 20-21)

Dr. Bauer did agree that the FCE report contains multiple complaints from Petitioner about pain into his right shoulder during testing. (RX 3 @ 21)

Dr. Bauer agreed that Dr. Atluri diagnosed Petitioner with possible cervical radiculopathy and found Petitioner to have a positive Spurling's sign on examination. Dr. Bauer denied that Dr. Atluri's examination showed evidence of possible cervical radiculopathy. Dr. Bauer believed that sign was a result of Petitioner's forminal stenosis. (RX 3 @ 22) Dr. Bauer further agreed that at no time prior to the October 2010 FCE did Petitioner's records indicate a positive Spurling's sign. (RX 3 @ 23) Dr. Bauer denied that negative Spurling's signs before the FCE and positive Spurling's signs during Dr. Atluri's examination would indicate that Petitioner's examination had changed. (RX 3 @ 26)

Dr. Bauer did agree that neck pain, as Petitioner described it, could worsen over time. He further agreed that if Petitioner were injured during the FCE, his neck pain could have worsened over time. However, based upon what he thought was a lack of complaints during the FCE and no mention of neck pain in Dr. Aribindi's December 29, 2010 report, Dr. Bauer opined that Petitioner had an acute onset of neck pain in January 2011. (RX 3 @ 28-29)

Dr. Bauer further disputed that pain medication for a shoulder or wrist injury, already being taken by Petitioner, could mask pain from a cervical injury. (RX 3 @ 31)

Regarding Petitioner's symptoms during his October 2010 FCE, Dr. Bauer testified that he believed Petitioner only had pain in his right shoulder, but that pain with a C5-6 and C6-7 injury would not stop at the shoulder, but would radiate to the arm, forearm and hands. (RX 3 @ 33)

Dr. Bauer agreed that the cervical injury that Petitioner was treated for could cause radicular pain into either arm. (RX 3 @ 34)

W respect to (F) Whether the petitioner's current condition of ill-being is casually related to his accident, the Arbitrator hereby finds:

Left Wrist

After reviewing all testimony and evidence in this matter, the Arbitrator hereby finds that the current condition of Petitioner's left wrist is causally related to his June 20, 2007 work accident.

There is no real dispute as to the causal connection between Petitioner's work accident and the current condition of his left wrist. Petitioner's history in this case indicates that his left arm went through the rungs of the ladder as he fell on June 20, 2007. When Petitioner reported to the emergency room that day, he was diagnosed, in part, with a Colle's fracture in the left wrist. (PX 9) Petitioner then underwent an open reduction and internal fixation, with volar plating in the left wrist on June 27, 2007. Petitioner was diagnosed during surgery with left distal radius fracture, intraarticular, comminuted. (PX 6)

Following this first wrist surgery, Petitioner continued having pain and discomfort in the wrist, which lead to two additional surgeries, first to remove and replace Petitioner's left wrist hardware and another to again remove hardware and perform an open reduction and internal fixation of the left wrist. (PX 6)

Petitioner continued an extensive course of treatment for his left wrist following the three surgeries. On April 28, 2010, Petitioner's treating surgeon, Dr. Anderson, reported that Petitioner continued to have pain and discomfort in the wrist with movement and that Petitioner had decreased strength and pain in the left wrist while working. At that time, Dr. Anderson stated that he recommended Petitioner "find another line of work that only requires lighter-duty type activities. As stated previously, heavy activity and repetitive heavy motion, would cause exacerbation of arthritic symptoms. Unrestricted duty in a career conducive to light activity would be recommended and encouraged for relief of long-term arthritis management." (PX 4)

Respondent has offered no evidence or testimony to dispute the causal connection between the condition of Petitioner's left wrist and his June 20, 2007 work accident. In fact, Respondent's own Section 12 examiner, Dr. Atluri, causally relates the condition of Petitioner's left wrist to his June 20, 2007 work accident, stating that the "on-going and progressively worsening symptoms in this patient's left wrist would be considered a combination of the deformity, malunion and post traumatic arthrosis from his injury from May of 2007 as well as any forceful or heavy use of his left hand and wrist subsequent to that injury which may have aggravated his condition." (RX 1)

Based upon all evidence and testimony in this matter, the Arbitrator hereby finds that the current condition of Petitioner's left wrist is causally related to the petitioner's June 20, 2007 work accident. All care and treatment for Petitioner's left wrist is also causally related to his June 20, 2007 work accident.

Cervical Spine

After reviewing all evidence and testimony in this matter, the Arbitrator hereby adopts the causation opinion of Dr. Cary Templin and finds that the current condition of Petitioner's cervical spine is casually related to his June 20, 2007 work accident.

It is clear from a review of the records and from the credible testimony of Petitioner that he sustained an injury to his cervical spine on June 20, 2007 and a worsening of that condition during his October 2010 FCE. The symptoms of Petitioner's injury first manifested themselves as pain into Petitioner's posterior right shoulder and down his right arm. Petitioner's right shoulder and arm pain continued throughout his course of treatment, even after right shoulder surgery. His pain worsened after the October 2010 FCE with increased pain into his neck, and was resolved only after he underwent a cervical fusion in May 2011.

As Dr. Templin explained in his deposition testimony, "I think that what is important is that the patient notes shoulder pain, continued shoulder pain. He had shoulder pain in August of 2007, he's had shoulder pain all along, and he underwent a shoulder surgery that really didn't do much for him. In this note here, he continues to

have shoulder pain. He notes shoulder pain during his FCE. He then develops severe shoulder, neck, and arm pain, has surgery for it, and it all gets better." (PX 12 @ 22)

Although Petitioner's first complaints of shoulder pain do not appear in the records until August 23, 2007, Dr. Templin explained, and Petitioner testified, that his right shoulder pain had been there since his June 20, 2007 accident but he began to focus on his right shoulder pain once the severe pain in his left wrist calmed down. Dr. Templin further pointed out that Petitioner had an extremely bad wrist injury that may have led him away from cervical and shoulder complaints right after the accident. However, when the wrist pain became better controlled, Petitioner began complaining of right-sided neck and shoulder pain. (PX 12 @ 27-28)

Later, following Petitioner's October 2010 FCE, he began complaining of drastically increased pain in the neck and right shoulder. This increase was detailed by Petitioner's complaints of "electric shock" type pain into his arms during the FCE. Petitioner was seen in November of 2010 by Dr. Atluri for Respondent's Section 12 exam. Dr. Atluri noted Petitioner's positive Spurling's maneuver at that time and diagnosed possible cervical radiculopathy. Petitioner also complained of extreme neck and arm pain when he reported to Porter Memorial Hospital emergency room on January 15, 2011 that dated back to the FCE in October. Petitioner testified that the pain which lead him to the emergency room in January of 2011 was of the same pain pattern as the pain that he felt during the October FCE. Petitioner then began treatment with Dr. Boyer for his cervical spine in March of 2011, leading to a cervical fusion surgery.

The arbitrator finds the testimony of Petitioner concerning the development of right shoulder pain following his June 20, 2007 accident and worsening neck, shoulder and arm pain after the October 2010 FCE, to have been honest and credible.

Respondent contends that Petitioner's cervical injury is not related to his June 20, 2007 accident based upon the opinion of Dr. Jerry Bauer. The Arbitrator has reviewed all medical records and testimony and has found the opinion of Dr. Templin more persuasive than Dr. Bauer. It is clear from a review of Dr. Bauer's report and testimony that he never considered whether Petitioner's right shoulder pain had been a symptom of his cervical spinal injury. Dr. Bauer simply dismissed Petitioner's reports of right shoulder pain from August of 2007 as "temporary." (RX 3 @ 9) However, it is clear from the records and Petitioner's credible testimony that his right shoulder pain continued from the date of his accident through the date of his cervical fusion on May 4, 2011, which resolved the petitioner's shoulder pain. The fact that Petitioner's shoulder pain was only resolved after cervical fusion was not a consideration that Dr. Bauer addressed in any way.

Furthermore, Dr. Bauer's opinion that Petitioner did not sustain a worsening of his cervical injury during his October 2010 FCE is wholly without merit. Dr. Bauer testified that he believed that Petitioner only complained of isolated right shoulder pain during the test. However, a review of the FCE and Petitioner's credible testimony reveals that Petitioner experienced "electric shock" type pain during the FCE, which Petitioner reported in his left wrist, fingers and up through his elbow, along with pain in the right shoulder. (PX 3) Dr. Bauer testified that if Petitioner was experiencing symptoms from a C5-6 and C6-7 injury, his pain could radiate to the arm, forearm and hands on either side, which is exactly how Petitioner's pain manifested during his October 2010 FCE. (RX 3 @ 33, 34) It is also clear that Dr. Bauer relied heavily on the lack of shoulder or neck symptoms reported to Dr. Aribindi on December 29, 2010 in finding that Petitioner's FCE did not aggravate the condition of his cervical spine. However, the Arbitrator has reviewed the December 29, 2010 record from Dr. Aribindi and has found that Dr. Aribindi was clearly examining Petitioner for left sided wrist issues. Dr. Aribindi's physical examination does not reflect he examined the shoulder or neck, and does not include any mention of the cervical spine or right shoulder whatsoever. Therefore, the Arbitrator gives little weight to whether or not Dr. Aribindi mentions symptoms that he was not asked to evaluate and clearly did not examine Petitioner for. Petitioner was next seen by Dr. Atluri, who diagnosed possible cervical radiculopathy,

and at the Porter Memorial Hospital emergency room where he was treated for severe neck and arm pain which Petitioner related back to the October 2010 FCE per the history in the emergency room. (RX 1; PX 10)

Based on the chain of events in this case, Petitioner injured his cervical spine on June 20, 2007. The pain from that accident was masked by his severe left wrist injury and the pain medication given for the left wrist. Petitioner continued to experience right shoulder pain throughout his treatment, with neck and right shoulder pain dramatically increasing following his October 2010 FCE. Only after Petitioner's cervical fusion were the pain in his neck and right shoulder improved.

Based upon the above reasoning, the Arbitrator finds that the current condition of Petitioner's cervical spine and all medical treatment for the cervical spine, including the May 4, 2011 diskectomy and fusion performed by Dr. Boyer, are causally related to the June 20, 2007 work accident. The condition that is causally related is the aggravation of degenerative arthritis of the cervical spine and spondylosis with radiculopathy as diagnosed by Dr. Templin, which required cervical fusion at C5-6 and C6-7.

Right Shoulder

Based upon all evidence and testimony in this matter, the Arbitrator hereby finds that the current condition of Petitioner's right shoulder is causally related to his June 20, 2007 work accident.

A review of the records in this case shows that Petitioner began complaining of right shoulder pain on August 23, 2007. Prior to that, as noted by Dr. Levenda, Petitioner had been focused upon the pain in his left wrist, even though he had been experiencing some right shoulder pain since his June accident. Dr. Levenda diagnosed Petitioner with impingement of the right rotator cuff, administered a cortisone injection and began Petitioner on a course of physical therapy. (PX 4)

Petitioner continued treating for right shoulder pain through October of 2008. At that time, Dr. Anderson notes that Petitioner had undergone a series of 8 injections, 2 months of formal physical therapy and 10 months of self-directed physical therapy. However, all treatment to the right shoulder had failed to relieve his symptoms. Therefore, on October 28, 2008, Petitioner underwent a right shoulder arthroscopy with debridement of degenerative SLAP tear, acromioplasty and distal clavicle excision, performed by Dr. Anderson. (PX 10)

Petitioner testified that his right shoulder pain improved for a time after surgery, but never went away. However, as exhibited by the records and as detailed in this decision above, Petitioner was also experiencing right shoulder pain due to a cervical spinal injury.

Based upon the records and evidence in this matter, the Arbitrator hereby finds that Petitioner sustained a right shoulder injury on June 20, 2013. Petitioner's right shoulder symptoms were caused by both a right shoulder injury, that was addressed through arthroscopic surgery, and a cervical injury that was addressed through cervical fusion. Following both of these treatments, Petitioner's right shoulder pain resolved.

The Arbitrator therefore finds that the current condition of Petitioner's right shoulder is causally related to his June 20, 2007 work accident and all care and treatment for his right should has also been causally related to his June 20, 2007 work accident. The condition of the right shoulder that is causally related to the accident is right shoulder impingement syndrome, right shoulder AC joint arthritis, right shoulder degenerative SLAP tear, and right shoulder pain secondary to a cervical radiculopathy.

With respect to issue (G) Petitioner's average weekly wage, (G), the Arbitrator hereby finds:

At trial, Petitioner reviewed the pay records contained in Petitioner's Exhibit 14. Petitioner testified that those pay records were accurate. He further testified that he worked 5 day work weeks, 8 hours per day. Any weekend work or work over 8 hours in a day would constitute overtime. Petitioner testified that overtime was mandatory. Respondent offered no testimony or evidence to dispute the validity of the pay records contained in Petitioner's Exhibit 14 or to dispute Petitioner's testimony that all overtime worked by the petitioner was mandatory.

The Arbitrator has reviewed Petitioner's pay records submitted as Petitioner's Exhibit 14 and has calculated the average weekly wage, pursuant to Section 10 of the Act, as follows:

Period Ending	Gross	OT Premium	Hours	Days	Weeks	Wage
6/24/2007	$1,050.00	$0.00	42.00	5.00	1.00	$1,050.00
6/17/2007	$1,375.00	$125.00	50.00	5.00	1.00	$1,250.00
6/10/2007	$1,412.50	$137.50	51.00	5.00	1.00	$1,275.00
6/3/2007	$375.00	$0.00	15.00	2.00	0.40	$375.00
5/27/2007	$1,000.00	$0.00	40.00	5.00	1.00	$1,000.00
5/20/2007	$1,187.50	$62.50	45.00	5.00	1.00	$1,125.00
5/13/2007	$1,181.25	$0.00	47.25	5.00	1.00	$1,181.25
5/6/2007	$1,618.75	$206.25	56.50	5.00	1.00	$1,412.50
	$9,200.00	$531.25	346.75	37.00	7.40	$8,668.75

TOTAL EARNINGS UNDER SECTION 10:	$8,668.75
NUMBER OF WEEKS AND PARTS THEREOF WORKED:	7.40
SECTION 10 AVERAGE WEEKLY WAGE:	$1,171.45
TEMPORARY TOTAL DISABILITY RATE:	$780.97

The Arbitrator includes all hours worked in the calculation of the AWW, backing out all overtime premium dollars. Petitioner's total Section 10 earnings excluding the overtime premium is $8,668.75. Petitioner's regular work week was 5 days. The number of weeks and parts thereof worked is 7.40 weeks. Based upon the above calculations, the Arbitrator hereby finds that Petitioner's average weekly wage, pursuant to Section 10 of the Act is $1,171.45.

With respect to issue (J) Were the medical services that were provided to the Petitioner reasonable and necessary, the Arbitrator hereby finds:

Having reconciled that the conditions of Petitioner's left wrist, right shoulder and cervical spine are all causally related to his June 20, 2007 work accident and all care and treatment for those conditions has also been causally related to his June 20, 2007 work accident, the Arbitrator hereby orders Respondent to pay outstanding medical bills as follows:

Provider	Beginning	Ending	Total Unpaid Original Charges	Total Unpaid Fee Schedule Charges	Total Due Pursuant to the Fee Schedule
AMC Anesthesia	5/4/2011	5/4/2011	$3,997.50	$2,786.67	$2,786.67
ATI	10/13/2010	10/13/2010	$2,459.16	$1,031.22	$1,031.22
Chicago Back Institute	3/17/2011	9/14/2012	$46,771.00	$22,475.68	$22,475.68

Dr. Anant Utturkar	6/20/2007	6/20/2007	$130.00	$98.80	$98.80
Dr. Baqhar Mohideen	1/15/2011	1/20/2011	$451.00	$342.76	$342.76
Diagnostic Radiology Specialists	3/17/2011	9/13/2011	$1,749.00	$1,704.12	$1,704.12
Indiana Physician Services	1/15/2011	1/15/2011	$1,106.00	$840.56	$840.56
IPN	10/5/2011	1/25/2013	$22,062.18	$18,417.42	$18,417.42
Lakeshore Bone & Joint	1/16/2011	3/8/2011	$4,399.00	$3,343.24	$3,343.24
Northwest Indiana Cardio Phys	1/15/2011	1/15/2011	$32.00	$24.32	$24.32
Pathology Consultants	1/15/2011	1/17/2011	$217.95	$165.83	$165.83
Phys 1st Neuro of Chicago	5/3/2011	5/3/2011	$5,369.00	$3,494.48	$3,494.48
Porter Hospital	1/15/2011	1/17/2011	$14,756.73	$11,215.12	$11,215.12
Radiologic Associates of NWIN	8/21/2012	8/21/2012	$358.00	$272.08	$272.08
SCH Laboratory Physicians	3/24/2011	5/5/2011	$247.00	$247.00	$247.00
Southland Rheumatology Center	12/29/2010	2/16/2011	$699.00	$463.26	$463.26
Summit Pharmacy	8/10/2012	10/3/2012	$263.87	$263.87	$263.87
Swedish Covenant Hospital	3/17/2011	6/8/2012	$101,798.91	$66,334.38	$66,334.38
Unity Physician Group	6/21/2007	6/21/2007	$353.00	$268.28	$268.28
Valley Regional Medical Center	6/20/2007	6/20/2007	$2,596.68	$1,973.48	$1,973.48
Totals			**$209,816.98**	**$135,762.57**	**$135,762.57**

The Arbitrator orders that Respondent shall pay reasonable and necessary medical services of $135,762.57, as provided in Sections 8(a) and 8.2 of the Act. This amount is the fee schedule amount, pursuant to Section 8.2 of the Act.

With respect to issue (L) Temporary Total Disability benefits, the Arbitrator hereby finds:

The records in this case reflect that Petitioner was taken off work due to his left wrist injury on June 21, 2007 when he was seen for the first time at Porter Memorial Hospital. (PX 10) Petitioner was seen the next day at Lakeshore Bone and Joint Institute by Dr. Levenda, who also kept him off work. (PX 4)

Petitioner remained either completely off work or on work restrictions through January of 2009. Respondent has offered no evidence to indicate that a light duty job offer was ever made to Petitioner while he was on restrictions. On January 5, 2009, Petitioner was released to return to work at full duty by Dr. Anderson. (PX 4)

On April 28, 2010, due to continued pain and discomfort in Petitioner's left wrist, Dr. Anderson stated that he recommended Petitioner "find another line of work that only requires lighter-duty type activities. As stated previously, heavy activity and repetitive heavy motion, would cause exacerbation of arthritic symptoms. Unrestricted duty in a career conducive to light activity would be recommended and encouraged for relief of long-term arthritis management." (PX 4) There has been no evidence offered by Respondent that any work has been offered within these restrictions.

In his IME report, Dr. Templin indicates that he did not believe Petitioner would require any restrictions for his cervical spine based upon how well the petitioner had reacted after surgery. However, Petitioner has been placed on restrictions by his treating surgeon, Dr. Boyer, for his cervical spine beginning on March 17, 2011 and continuing through the date of trial in this case. On June 8, 2012, Dr. Boyer, who performed Petitioner's cervical fusion surgery, placed Petitioner at maximum medical improvement for his cervical spine with a permanent restriction of 25 pounds maximum lifting. (PX 5)

Respondent's Section 12 examiner, Dr. Bauer, does not address any possible restrictions for Petitioner's cervical spine.

Based upon either the restrictions for Petitioner's left wrist or the restrictions for his cervical spine, it is clear that Petitioner is not able to return to his previous employment as a service technician. No vocational rehabilitation assistance or light duty job offers have ever been made to Petitioner in this case.

Based upon the above information, the Arbitrator hereby orders that Respondent shall pay petitioner temporary total disability benefits of $780.97 per week for 257.85 weeks, commencing June 21, 2007 through January 5, 2009 and April 28, 2010 through September 18, 2013, as provided in Section 8(b) of the Act.

With respect to (M) Whether penalties or fees should be imposed upon Respondent, the arbitrator hereby finds:

The Arbitrator finds there has been no unreasonable or vexatious behavior on the part of Respondent with respect to payment of TTD benefits, or with respect to non-payment of the medical bills for the cervical surgery. Dr. Anderson's records indicate Petitioner was released to full duty on two different occasions, and Respondent reinstated TTD benefits immediately upon Dr. Atluri's medical report. Also, a legitimate dispute existed as to whether Petitioner's cervical condition of ill-being was causally related to the accident herein.

STATE OF ILLINOIS)
) SS.
COUNTY OF KANE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Michael Shered,
Petitioner,

vs.

NO: 11WC 46585

15IWCC0040

Northern Illinois University,
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, temporary total disability, causal connection, medical, prospective medical, 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 31, 2014, is hereby affirmed and adopted.

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

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

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

DATED: JAN 20 2015
o011515
DLG/jrc
045

David L. Gore

Mario Basurto

Stephen Mathis

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

SHERED, MICHAEL
Employee/Petitioner

Case# **11WC046585**

15IWCC0040

NORTHERN ILLINOIS UNIVERSITY
Employer/Respondent

On 7/31/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% 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 LAW OFFICE OF JIM BLACK
TRACY L JONES
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ROCKFORD, IL 61101

0499 DEPT OF CENTRAL MGMT SERVICES
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0904 STATE UNIVERSITY RETIREMENT SYS
PO BOX 2710 STATION A*
CHAMPAIGN, IL 61825

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

JUL 31 2014

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

15IWCC0040

STATE OF ILLINOIS)
)SS.
COUNTY OF KANE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Michael Shered
Employee/Petitioner

v.

Northern Illinois University
Employer/Respondent

Case # **11** WC **46585**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gerald Granada**, Arbitrator of the Commission, in the city of **Geneva**, on **6/20/14**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **8/26/09**, 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 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 $**39,561.60**; the average weekly wage was $**760.80**.

On the date of accident, Petitioner was **53** years of age, ***married*** with **0** dependent children.

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

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

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

ORDER

Petitioner failed to meet his burden of proof on the issues of notice and accident. Accordingly, all benefits are denied.

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

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

Signature of Arbitrator

7/30/14
Date

JUL 31 2014

FINDINGS OF FACT

This is a claim for benefits in which the Petitioner alleges a work injury to his right knee occurring on August 26, 2009. The issues in dispute are: accident, notice, causation, medical expenses and TTD. Petitioner is also claiming in the alternative that he is either permanently and totally disabled or requires an evaluation for permanent restrictions and vocational rehabilitation with maintenance benefits.

Petitioner Michael Shered testified he lives in Dekalb, Illinois, and was working for NIU in 2009. Petitioner started working at NIU in 1994 and his job title in 2009 was Building Service Worker. As a Building Service Worker, Petitioner retrieved trash, washed walls and windows, stripped floor, and shampooed and waxed floors. Petitioner was working on mostly janitorial services.

According to Petitioner's testimony, on August 26, 2009, he was working in the shower areas of Douglas Hall. He testified that while he was working in the bathroom he slipped and fell on his knee. He testified he was cleaning the bathroom at the time when he fell and was mixing up chemicals and spraying them on the walls and floors. He let the chemicals sit so it would work through the grime and it could then be scrubbed and rinsed. He testified he slipped and fell on his right knee on the combination of chemicals and water, and that there was soap and water on the floor in the area that he was standing when he fell. Petitioner testified that when he fell, his knee hurt and he took a minute to get up and sit down on a bench. He did not recall how long he sat on this bench.

Petitioner testified that he told his supervisor, Chad Folowell about this incident. Petitioner further testified that this discussion took place in Mr. Folowell's office, which was located in the basement of Douglas Hall.

On September 28, 2009, Petitioner first sought medical treatment after this incident with Dr. Morker. Petitioner was subsequently referred to see Dr. Glasgow, an orthopedic specialist. On October, 2009. Petitioner followed up with Dr. Glasgow and underwent an injection to his knee. Petitioner did not obtain relief from his injection and a knee replacement surgery was recommended. Petitioner testified he talked to Chad Folowell again about his knee in October 7, 2009, at which time he told Mr. Folowell the doctor suggested to Petitioner that he have his knee replaced.

On October 23, Petitioner underwent knee replacement surgery. He later underwent a surgical manipulation procedure on December 3, 2009. Petitioner underwent physical therapy and received a full duty release to work on March 1, 2010. On August 10, 2010, Petitioner underwent a third surgery by Dr. Glasgow, which was followed up by additional physical therapy. According to Petitioner's testimony, a fourth surgery was recommended by never took place. Petitioner testified that at the time of the arbitration, it had been two years since he last saw Dr. Glasgow and that according to Dr. Glasgow's orders, Petitioner has not returned to work.

On October 24, 2012, Dr. Coe examined Petitioner at the request of Petitioner's counsel. Subsequently, Respondent had Petitioner examined by Dr. Noh on April 8, 2013. Both doctors found a causal relationship between the event described to them from August 26, 2009 and Petitioner's right knee condition.

Since his last visit with Dr. Glasgow, Petitioner has not returned to work in any capacity and his knee remains stiff. He uses a cane that keeps him from falling. He testified that he is not able to work long periods, not able to run, and not able to stand for prolonged periods without pain. He cannot kneel or squat on the ground without pain. He climbs stairs very slowly and cannot climb ladders.

Petitioner signed an "AMENDED" Application for Adjustment of Claim on December 2, 2011, in which he indicates an accident date of December 1, 2009. (RX 1) Petitioner then subsequently filed a "SECOND Amendment" AMENDED Application for Adjustment of Claim in which he indicates an accident date of August 26, 2009. (RX 2) Petitioner then completed a CMS Workers' Compensation Employee's Notice of Injury form, which is dated January 9, 2013 in which he indicates the date of injury or illness as "7 (mo) 09 (year) . (RX 3)

During his cross examination, Petitioner testified that he did not recall exactly when he fell or when he told Chad Folowell about the fall.

Chad Folowell testified on behalf of the Respondent. He has been working for the Respondent for 19 years, beginning as a janitor. He took on the role of supervisor beginning in October 199 and has been Petitioner's supervisor for 10 years. Folowell confirmed that Petitioner discussed with him going off work on FMLA to get Petitioner's knee fixed, but never mentioning any slip or fall in a shower. Folowell also noted that the Petitioner wore a knee brace at work, but the Petitioner never mentioned it was related to work. Folowell also testified that he would sit with the Petitioner in the brake room on a regular basis and the Petitioner never mentioned a slip and fall in the shower or a work injury. Folwell confirmed that he has 15 employees report accidents in the past and that the procedure for reporting an accident involves filling out a form and calling an 800 number. Additionally, Folowell also has his own cellular phone number posted in the brake room in case his employees need to reach him. Folowell testified he had no knowledge having fallen at work.

CONCLUSIONS OF LAW

1. With regard to the issue of notice, Petitioner has failed to provide timely notice of his accident to the Respondent within the time period mandated by the Act. In this case, the Arbitrator finds persuasive the testimony of Chad Folowell, who denied ever receiving notice of the Petitioner's alleged accident until 2013 – over three years following the alleged incident. This conclusion is further supported by the fact that the Petitioner has claimed at least three different accident dates: 1) December 1, 2009 per the Amended Application for Adjustment of Claim (RX 1); 2) August 26, 2009 per the "SECOND Amendment" Application (RX 2); and 3) July, 2009 per the Employee's Notice of Injury (RX 3). And finally, we have the Petitioner's own testimony on cross examination, wherein he testified that he does exactly recall when his accident occurred or when he told his supervisor. All of these factors unduly prejudice the Respondent in this case. Accordingly, the Arbitrator concludes that the Petitioner failed to provide proper notice as mandated under Section 6c of the Act.

2. Petitioner has failed to meet his burden of proof with regard to the issue of accident. In support of this finding the Arbitrator relies on the findings that address the issue of notice – namely, the Petitioner's inability to recall when he sustained an injury and the fact that his testimony about notice was directly rebutted by his supervisor Chad Folowell. However, the Arbitrator also looks to the medical records of

the Petitioner's treating physicians, all of which are devoid of any mention of the Petitioner injuring his knee at work or falling in the shower. The lack of any contemporaneous medical evidence supporting the Petitioner's history of falling at work and injuring his right knee, coupled with the multiple accident dates alleged and the testimony of Chad Folowell – all work to obliterate the credibility of Petitioner's accident claim. Accordingly, the Arbitrator concludes that the Petitioner failed to prove that he sustained an accident on August 26, 2009.

3. Based on the findings above, all other issues are rendered moot.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Alberto Davila,

Petitioner,

vs. NO: 13WC 18545

Areatha Construction,

15IWCC0041

Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b)/8(a) 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. 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 24, 2014, 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.

15IWCC0041

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: JAN 20 2015

David L. Gore

Mario Basurto

Stephen Mathis

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DLG/jrc
045

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

DAVILLA, ALBERTO
Employee/Petitioner

Case# **13WC018545**

AREATHA CONSTRUCTION
Employer/Respondent

15IWCC0041

On 6/24/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% 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:

1357 RATHBUN CSEVENYAK & KOZOL
LUIS J MAGANA
3260 EXECUTIVE DR
JOLIET, IL 60431

5074 QUINTAIROS PRIETO WOOD & BOYER
BRIAN HINDMAN
180 N STETSON AVE SUITE 4525
CHICAGO, IL 60601

15IWCC0041

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

Alberto Davila
Employee/Petitioner

v.

Areatha Construction
Employer/Respondent

Case # **13** WC **18545**

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 **6/6/14**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

15IWCC0041

FINDINGS

On **5/16/14**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did*** 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 **$72,748**; the average weekly wage was **$1,399.00**.

On the date of accident, Petitioner was **40** years of age, ***married*** with **3** 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 **$7,064.14** for TTD, $ for TPD, $ for maintenance, and $ for other benefits, for a total credit of $.

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

ORDER

Petitioner failed to prove that his current condition of ill-being is causally related to any work incident or injury while in the employ of Respondent. Petitioner reached maximum medical improvement on July 8, 2013.

All additional claims by Petitioner for TTD and prospective medical care in this matter are thereby 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

06·24·14
Date

JUN 24 2014

15IWCC0041

ILLINOIS WORKERS' COMPENSATION COMMISSION

ALBERTO DAVILA,	)	
	)	
Petitioner,	)	
	)	13 WC 18545
AREATHA CONSTRUCTION	)	
	)	
Respondent,	)	

FINDINGS OF FACT

Petitioner testified that he injured his low back on May 16, 2013, while lifting concrete forms made of metal.

Petitioner initially reported to Loyola Emergency Department on May 16, 2013 and was evaluated by Dr. Boyle. Dr. Boyle authorized Petitioner to return to work with restrictions: no lifting over 10 lbs (bucket of water), avoid strain to back, further instructions per his doctor. (PX #5).

On May 16, 2013, Petitioner underwent an MRI at Loyola University Medical Center. The impression was "mild lumbar spondylosis." At L3-L4, there was a small disc bulge causing no significant central spinal stenosis and no neural foraminal stenosis. At L4-L5, there was a disc bulge and small superimposed right paracentral disc protrusion causing mild central spinal stenosis and mild bilateral inferior neural foraminal stenosis. At L5-S1, there was a disc bulge with small superimposed central protrusion resulting in mild central spinal stenosis and mild left neural foraminal stenosis, the right neural foramen was widely patent. (PX. 4).

Petitioner returned to Loyola Emergency Department and was evaluated by Dr. Davenport. Petitioner was authorized to return to work with no restrictions on May 28, 2013. (PX #5).

Petitioner testified that he was told to see a spine specialist by the doctors at Loyola. **However, Petitioner's records are silent as to the alleged referral.**

On June 20, 2013, Petitioner presented to Illinois Spine and Scoliosis Center and was evaluated by Dr. Anthony Rinella. Dr. Rinella noted that Petitioner is a 40 year old laborer injured at work on May 16, 2013. Petitioner completed a pain diagram indicating pain in the anterior **left thigh** and **low back**. He stated that there were **no right sided symptoms** and that he had had no other treatments. Petitioner stated that he had required narcotics for issues related to his feet but never for his lumbar spine. Dr. Rinella reviewed the MRI from May 16, 2013. Dr. Rinella stated that the MRI revealed "disc herniation at L4-L5 and L5-S1. The axial images demonstrate central narrowing at L4-L5 and L5-S1 extending into the left lateral recess." Dr. Rinella's impression was:

1. Lumbar sprain
2. Lumbar spondylotic radiculopathy.

Petitioner was told to return to work with a 10 pound weight restriction, no repetitive bending or twisting. Dr. Rinella recommended a formal course of physical therapy 3 days a week for the next 6-8 weeks and a follow up in 6 weeks. Petitioner was given Norco and prescribed Flexeril. (PX #6).

On July 8, 2013, Petitioner presented to Dr. Mather at M&M Orthopaedics for a Section 12 Examination. Dr. Mather noted that Petitioner is a 40 year old male who alleged an injury on May 16, 2013 working for Areatha Construction. Petitioner stated that when he was working as a laborer on some concrete poles, around 9:15 a.m., he injured his back pulling them up out of the ground. Dr. Mather noted and Petitioner testified that he had only been back to work for 2 days after being off for 11 months after an injury to his right foot, which was treated non-

operatively. Dr. Mather noted that Petitioner speaks very little English, though he stated that he reported his injury to his supervisor and he was told to go home. Petitioner went to Loyola Urgent Care on the same day. He stated that he had no history of back problems. Petitioner stated that he was going to see Dr. Rinella on July 20, 2013 to determine if the injections would be necessary. (RX #1).

Dr. Mather reviewed the actual MRI images from May 16, 2013 and stated that "this shows a very small right L4-L5 disc protrusion, noncompressive. There is nothing on the left side at any level to validate his complaints of numbness of the anterior thigh and certainly nothing that would validate loss of vibratory sense in the lower left extremity. Maybe some mild disc degeneration at L5-S1; perhaps mild disc desiccation at L3-4." (RX #1).

Dr. Mather's impression was:

1. Low back lumbar strain,
2. Functional overlay/psychogenic pain.

He noted "it is my professional opinion and medical opinion that Alberto Davila most likely had a lumbar strain on or about May 16, 2013. This strain, given the above information, should have lasted approximately 2 weeks based on my review of the history, physical examination, MRI images, x-rays, and accompanying medical records. It should be noted that I reached these conclusions only after very careful and thoughtful review of the above information." (RX #1). Dr. Mather recommended that Petitioner return to work with no restrictions. He stated that Petitioner did not need any more physical therapy and did not require injections. He noted that the lumbar epidural steroid injections are not condoned by the American Pain Society Guidelines of 2009 in the **absence of radicular pain.** (RX #1).

Dr. Mather stated that Petitioner had no objective findings on examination by any physician. Dr. Mather stated that both he and Dr. McAndrew noted positive Waddell findings on examination. He stated that Petitioner's disc protrusion was small and noncompressive. He said that these disc protrusions are commonly found in an asymptomatic population in a high percentage of patients Petitioner's age (40%). He added that Petitioner's left anterior thigh numbness does not correlate with any MRI findings or physical exam findings. (RX #1).

Dr. Mather opined that Petitioner had reached MMI and could work without restrictions. (RX #1).

On August 2, 2013, Petitioner returned to Dr. Rinella at Illinois Spine and Scoliosis Center. He noted mild numbness in the left anterior thigh and said it is not a significant problem at the time. He complained of pain at 7/10. Dr. Rinella noted "Despite his recommendations to return to work without restrictions, his work could not comply." (PX #6). Dr. Rinella's impression remained lumbar strain. He reviewed Dr. Mather's IME report. He disagreed with Dr. Mather's feeling that there was symptom magnification. However, at the time, Dr. Rinella did not believe that injection or surgical invention would be beneficial. He recommended a home exercise program and a return to work with a 25 pound weight restriction, no repetitive bending or twisting. Petitioner stated that he would like to see a Podiatrist for toe fractures (from a previous injury in 2012). (PX #6)

On September 13, 2013, Petitioner returned to discuss his lumbar back pain with Dr. Rinella. Dr. Rinella noted that Petitioner had tenderness in his lumbosacral region and pain radiating down the **right** posterior thigh with some anterior thigh symptoms. Dr. Rinella clarified his last note by saying "there was an error on my last note reporting left-sided symptoms. Dr. Rinella recommended a right L4-L5 transforaminal injection to address his right leg symptoms.

He mentioned consideration of a lumbar discogram to assess whether he was having true discogenic pain. Dr. Rinella provided work restrictions limiting weight to 25 pounds with no repetitive bending and twisting. Petitioner was told to follow up in six weeks. (PX #6)

Petitioner testified at trial that his pain started on the left side, and over time, he became more symptomatic on the right side.

On September 18, 2013, Petitioner underwent a transforaminal epidural steroid injection into the lumbar spine performed by Dr. Faris Abusharif at Pain Treatment Centers of Illinois. (PX #4).

On October 2, 2013, Petitioner underwent a lumbar epidural steroid injection performed by Dr. Faris Abusharif at Pain Treatment Centers of Illinois. (PX #4).

On October 16, 2013. Petitioner underwent a third lumbar epidural steroid injection performed by Dr. Faris Abusharif at Pain Treatment Centers of Illinois. (PX #4).

On October 25, 2013, Petitioner returned to follow up with Dr. Rinella after his three injections. He noted that the first injection provided 50% relief but the second and third provided no relief. Petitioner also complained of erectile dysfunction over the past few months which had become concerning for him. Dr. Rinella recommended a discogram in efforts to localize the pain generators in his lumbar spine. Dr. Rinella provided work restrictions limiting weight to 25 pounds with no repetitive bending and twisting. Petitioner was told to follow up with his urologist regarding the complaint of erectile dysfunction. (PX #6)

On November 26, 2013, Petitioner reported to Dr. Abusharif and complained of pain in the low back with occasional radiation in to the right buttock. (PX. 4).

On December 4, 2013, Petitioner underwent a CT of the lumbar spine post discogram. The findings were as follows:

1. Lumbar discograms were performed
2. L3-L4: Contrast is contained within the annulus fibrosis. No contrast extravasation beyond the periphery of the disc. No evidence of annular tear.
3. L4-L5: Curvilinear areas of non-filling of the contrast seen representing degenerative disc disease. Contrast is seen extravasating through the posterior central disc space and is extending along the periphery of the disc in the posterior half. Posterior central annular tear.
4. L5-S1: Curvilinear areas of non-filling of the contrast seen representing degenerative disc disease. Contrast is seen extravasating through the posterior central disc space and is extending along the periphery of the disc in the posterior half. Posterior central annular tear.
5. Bilateral neural foraminal narrowing noted L4-L5 and L5-S1. (PX #4).

On December 11, 2013, Petitioner reported pain in the low back with radiating into the buttock and bilateral legs. (PX. 4).

On December 26, 2013, Petitioner returned to follow up with Dr. Rinella. Petitioner complained of pain at 7/10 and said that he felt he was deteriorating. Dr. Rinella stated **"he does not have significant radiating symptoms at this time."** Dr. Rinella's impression after the discogram was "lumbar discogenic pain L4-L5 and L5-S1 (confirmed by 12/4/13 discography.)" Dr. Rinella recommended a transforaminal lumbar interbody fusion at L4-L5 and L5-S1 and authorized Petitioner off work. Petitioner was told to follow up in 6 weeks. (PX #6).

On January 15, 2014 Petitioner reported pain in the low back with radiating into the buttock and bilateral legs. (PX. 4).

On February 6, 2014, Petitioner returned for a follow-up with Dr. Rinella. Petitioner complained of pain radiating to his **right anterior and posterior thigh, with no left sided symptoms. He rated the pain at 10/10**, which was an increase in comparison to his last

evaluation. Dr. Rinella authorized Petitioner off work and renewed his recommendation for a transforaminal lumbar interbody fusion at L4-L5 and L5-S1. (PX #6).

Also on February 6, 2014, Dr. Rinella provided a narrative report reiterating his diagnosis and recommendations for a transforaminal lumbar interbody fusion at L4-L5 and L5-S1. Dr. Rinella again stated that **Petitioner initially had left anterior thigh pain**. Dr. Rinella stated that Petitioner could work with a 25 pound lifting restriction. Dr. Rinella stated "without surgery, I anticipate his symptoms will stay more or less the same. As of my last visit earlier this month, Petitioner was rating his pain at 10/10. He was no longer taking Norco doe to his insurance limitations and Tramadol was not sufficient. Therefore, with his current healing trajectory I anticipate he will have a very poor prognosis without surgical interventions." Dr. Rinella disagreed with Dr. Mather's opinions because Dr. Mather did not have the benefit of reviewing a lumbar discography. Dr. Rinella stated that his own diagnosis of lumbar radiculopathy was confirmed by the injections that occurred after Dr. Mather's evaluation. However, he agreed with Dr. Mather with the fact that a lumbar strain was present at the time of Dr. Mather's evaluation. Finally, Dr. Rinella said that he saw no signs of malingering or untruthfulness in his evaluations with Petitioner. (PX #3).

On February 26, 2014, Petitioner told Dr. Abusharif that his back pain radiates into the **right leg** and **right knee**. (PX. 4).

On March 21, 2014, Petitioner returned to Dr. Rinella. Dr. Rinella stated that Petitioner initially had pain in his back that extended into **his left anterior thigh.** Dr. Rinella noted that by February 6, 2014, Petitioner's symptoms in his lower extremity were more on his **right anterior thigh** and posterior thigh than on the left. (PX #6).

On May 2, 2014, Petitioner returned to see Dr. Rinella. Petitioner told Dr. Rinella that he had a hard time getting "out of a couch." (PX #6). Petitioner testified at trial that his hobbies include walking around the neighborhood and admitted to being able to walk.

On March 6, 2014, Petitioner told Dr. Abusharif that his low back pain was radiating into the right buttock, right hip, right leg and right foot. (PX. 4).

On April 23, 2014, Petitioner told Dr. Abusharif that his low back pain radiates into the **right buttock, right leg and right foot**. (PX. 4).

On June 2, 2014, Dr. Mather authored an addendum report after reviewing additional records. He stated "given the fact that the lumbar diskogram was done without any idea of how much pressure was used to inject the disc, this is clearly an invalid lumbar diskogram. It is widely accepted that pressurization of the disk re-creating dickogenic pain should occur below 50 PSI. Pain above 50 PSI would indicate a nonspecific test. Therefore, this test is invalid. Multiple articles support this opinion." (RX #1). Dr. Mather stated that Petitioner completed a pain diagram when he reported for the IME which indicated back pain to posterior left thigh pain. He pointed out that **radiculopathy would indicate symptoms below the knee**. He added, "this patient does not have true radiculopathy." (RX #1). He stated that Petitioner does not have radicular pain, but has nonspecific thigh pain which appeared to vacillate between the right and left sides. He opined that Petitioner's erectile dysfunction is unrelated to the lumbar spine. Dr. Mather noted that there was no nerve root compression noted on the MRI studies because if there was, a lumbar diskogram certainly would not have been ordered because a lumbar diskogram is ordered when there are no findings of radiculopathy or nerve root compression seen on the MRI. He stated that Petitioner's symptoms were inconsistent. Dr. Mather added "I would go so far as to predict this patient would have a poor outcome with an L4 to S1 fusion." (RX #1).

F. In support of the Arbitrator's Decision as to whether Petitioner's present condition of ill-being is causally related to the injury, the Arbitrator makes the following findings:

This Arbitrator, having reviewed the medical records submitted into evidence, finds Dr. Mather to be more credible than Dr. Rinella. Petitioner testified at trial that his symptoms started on the left side. Over time, his symptoms migrated to the right side. He has not sustained his burden of proving that these inconsistent symptoms are related to his work injury of May 16, 2013.

Further, the May 16, 2013 MRI report contained in Petitioners Exhibit #4 shows only minimal disc bulging that is commonly found in approximately 40% of the male population Petitioner's age. According to Dr. Mather, having personally reviewed the MRI films, Petitioner's initial left leg symptoms did not correlate to any MRI findings or physical exam findings. This Arbitrator finds Dr. Mather's reasoning compelling. It was not until September 13, 2013, 4 months after the injury, that Petitioner began to complain of pain on the right anterior and posterior thigh. Dr. Mather stated that Petitioner does not have true radiculopathy. Given that Petitioner's pain complaints varied and were inconsistent, this Arbitrator agrees with Dr. Mather's opinion.

This Arbitrator finds that Dr. Rinella is less convincing than Dr. Mather. Dr. Rinella stated in his February 6, 2014 narrative report that "I clarified in my previous notes much of the left-sided symptoms were in error." [*emphasis added*] (PX. #3). However, his previous note of December 26, 2013, Dr. Rinella stated, "he does not have any significant radiating symptoms at this time."[*emphasis* added] (PX #4). Dr. Rinella's records become even more confusing and therefore hard to find credible because on September 13, 2013, he said "there was an error on my last note reporting left-sided symptoms." (PX #6). The previous note to which he was referring,

dated August 2, 2013, states that petitioner had mild numbness in his left anterior thigh, but it was not a significant problem at the time. Whichever side the pain was actually on, it was not a significant complaint. Further, Petitioner's testimony directly contradicts this statement because he said that the pain started on the left side and then migrated to the right side. Dr. Rinella causes further confusion in his August 2, 2013 note by saying "Despite my recommendations to return to work without restrictions, his work could not comply." (PX #6). There is no record that supports this statement. In Dr. Rinella's attempts to advocate for his patient, he raises questions as to the reality of Petitioner's pain complaints because his records are contradictory to themselves and to Petitioner's testimony. Therefore, this Arbitrator has difficulty to finding Dr. Rinella's opinions to be credible.

Petitioner testified at trial that he was referred to Dr. Rinella by the doctors at Loyola, but produced no medical evidence to support his assertion. The last note from Loyola is dated May 28, 2013 and indicates that Petitioner was released with no restrictions.

At trial, Petitioner testified that his pain was severe. On February 6, 2014, Petitioner stated that his pain was 10/10. (PX #6). A pain rating of 10/10 would indicate to this Arbitrator that Petitioner was in such debilitating pain that he could not walk, stand or sit. However, at trial, Petitioner sat for approximately 40-45 minutes and did not need to stand and did not appear in discomfort. Further, Petitioner testified that he was able to walk and enjoys walking around his neighborhood. Based on this testimony, this Arbitrator agrees with Dr. Mather's opinion that Petitioner has psychogenic pain.

Finally, Petitioner testified at trial that he was unaware of Dr. Mather's opinions that and L4 to S1 fusion would have a very poor outcome. Weighing the evidence carefully, this

Arbitrator is hesitant to award a surgical fusion without Petitioner being aware of the potentially poor outcome of surgery as discussed by Dr. Mather.

After carefully weighing the evidence, due to the inconsistent treating medical records, review of the MRI, Petitioner's testimony and Section 12 report, this Arbitrator finds that Petitioner has not sustained his burden of proving that his current condition and the need for a surgery is causally related to the work injury of May 16, 2013. This Arbitrator finds that Petitioner reached maximum medical improvement on June 8, 2013, the date of Dr. Mather's independent medical examination.

J. In support of the Arbitrator's Decision as to whether the Respondent has paid all appropriate charges for all reasonable and necessary medical service, the Arbitrator makes the following findings:

Based on the foregoing, this Arbitrator finds that Petitioner has failed to establish that his current condition of ill being is causally related to the injury sustained at work on May 16, 2013 after being placed at maximum medical improvement by Dr. Mather on July 8, 2013. By extension, all other issues are rendered moot and all requested compensation and benefits are denied. The parties stipulated that Respondent paid medical benefits for dates of service prior to July 8, 2013. No other medical benefits are awarded.

K. In support of the Arbitrator's Decision as to the amount of compensation due for temporary total disability, the Arbitrator finds the following facts:

Based on the foregoing, this Arbitrator finds that Petitioner has failed to establish that his current condition of ill being is causally related to the injury sustained at work on May 16, 2013 after being placed at maximum medical improvement by Dr. Mather on July 8, 2013. By extension, all other issues are rendered moot and all requested compensation and benefits are denied.

O. Prospective medical care:

Based on the foregoing, this Arbitrator finds that Petitioner has failed to establish that his current condition of ill being is causally related to the injury sustained at work on May 16, 2013 after being placed at maximum medical improvement by Dr. Mather on July 8, 2013. By extension, all other issues are rendered moot and all requested compensation and benefits are denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

15IWCC0042

James Kwiatkowski,
Petitioner,
vs.

NO: 08WC 11515

Swift News Agency and the Illinois State Treasurer as *ex-officio* Custodian of the Injured Workers' Benefit Fund,
Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, temporary total disability, causal connection, medical, employer/employee relationship, notice, benefit rate, permanent partial disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 20, 2014, is hereby affirmed and adopted.

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

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

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

DATED: JAN 20 2015
o011515
DLG/jrc
045

David L. Gore

Mario Basurto

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

KWIATKOWSKI, JAMES
Employee/Petitioner

Case# **08WC011515**

15IWCC0042

SWIFT NEWS AGENCY AND THE IL STATE TREASURER AS EX-OFFICIO CUSTODIAN OF THE INJURED WORKERS' BENEFIT FUND
Employer/Respondent

On 8/20/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% 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:

2243 LAW OFFICE OF MITCHELL A KLINE
203 N LASALLE ST
SUITE 2100
CHICAGO, IL 60601

SWIFT NEWS AGENCY
30 NORTH ST
PARK FOREST, IL 60466

5165 ASSISTANT ATTORNEY GENERAL
JEANNIE D SIMS
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

STATE OF ILLINOIS)

)SS. 15IWCC0042

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

James Kwiatkowski
Employee/Petitioner

Case # **08** WC **11515**

v.

Consolidated cases: _____

Swift News Agency and the IL State Treasurer as *ex-officio* custodian of the Injured Workers' Benefit Fund
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Jessica Hegarty**, Arbitrator of the Commission, in the city of **Chicago**, on **June 4, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

15IWCC0042

15IWCC0042

FINDINGS

On **March 2, 2008**, Respondent-Employer ***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.

ORDER

Due to a finding that an employee-employer relationship did not exist between Petitioner and Respondent-Employer, no award is made in Petitioner's favor.

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

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

Signature of Arbitrator

8/20/14
Date

AUG 20 2014

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JAMES KWIATKOWSKI, **Petitioner,**	)	15IWCC0042
vs.	)	**No. 08 WC 11515**
SWIFT NEWS AGENCY and the ILLINOIS STATE TREASURER as *ex-officio* custodian of the ILLINOIS WORKERS BENFIT FUND, **Employer/Respondent.**	)	

ADDENDUM TO ARBITRATION DECISION

STATEMENT OF FACTS

This action was pursued under the Illinois Workers' Compensation Act by Petitioner who sought relief from Respondent-Employer, Swift News Agency. This action also sought relief from the Illinois Injured Workers' Benefit Fund because the employer allegedly did not maintain workers' compensation insurance. A hearing was held on June 4, 2014. Petitioner notified the employer of the hearing by mail. (Arb. Group Ex. 2). The employer did not appear for any of the arbitration proceedings and was not represented by an attorney. The Illinois Attorney General's Office appeared on behalf of the Illinois State Treasurer, as *ex-officio* custodian of the Injured Workers' Benefit Fund, and participated in the arbitration proceedings.

Petitioner was 53 years old on the date of accident. Petitioner did not provide any testimony regarding his marital status and whether or not he had any dependents on the date of accident. The Arbitrator notes that Petitioner alleges he was married on the date of accident. (Arb. Ex. 1). Petitioner testified that he began working for Swift News Agency in April 2007. He stated he found out about an open position from an unnamed friend and interviewed with an unnamed worker at Swift. Petitioner testified that his job duties at Swift included setting up zip codes for various towns, delivering newspapers up to twice a week, unloading trucks, and stacking newspapers. Petitioner worked approximately four to five days per week at Swift. Petitioner testified that he delivered papers on Thursday and Sunday each week. Petitioner drove his own vehicle when delivering papers. Petitioner testified he had to use electric floor lifts to unload trucks and move materials onto skids, which he described as being pallets made out of wood. Petitioner did not have a direct supervisor but did testify that someone in the office was in charge of the general oversight of the operation. Petitioner testified that part of his job was to generally know what was coming and going and keeping

track of Swift's trucks. Petitioner testified that no Swift employee told him each day which tasks to complete or the manner in which to complete those tasks; instead, once he started he knew what had to be done and he completed those tasks. Petitioner did not testify as to whether or not he had a set work schedule or a set amount of required hours.

Petitioner testified that he believed he was paid approximately $180.00 - $200.00 per week before the accident. Petitioner testified that he was only paid based on the actual work he completed, not on hours worked and he was not salaried. In particular, Petitioner testified that his pay was primarily based on the amount of zip codes he set up on a particular day. Petitioner provided no testimony regarding how much compensation he received for each task. Petitioner testified that Swift deducted taxes from his pay and issued W2s. However, Petitioner presented no evidence of ever having received any pay from Swift during the entire duration of his alleged employment. While Petitioner stated on cross-examination that he did have copies of W2s from Swift, no such documents were submitted into evidence.

Petitioner testified that he maintained concurrent employment as a snow remover for Arctic Snow and Ice Control, Inc. in the winter of 2008. Petitioner submitted evidence of this employment and wages earned in the form of paystubs. (PX 1). Petitioner testified he worked at Arctic Snow from January through February 2008. Petitioner testified that a fellow employee named Barb who worked in the front office knew about his employment because he would miss work at Swift when Arctic gave him plow jobs in the winter. Petitioner later identified Barb as a secretary. The submitted paystubs from Arctic Snow show Petitioner was paid weekly and cover the weeks ending on January 5, 2008, January 26, 2008, February 2, 2008, February 9, 2008, February 16, 2008, and February 23, 2008. In these six weeks, Arctic Snow paid Petitioner $1,786.00. *Id.* The exhibit includes an additional pay stub presumably from Arctic Snow; however, the Arbitrator is unable to determine that these additional earnings were received for work performed within 52 weeks prior to the alleged date of accident. The Arbitrator notes that Petitioner also submitted pay stubs from Coluzzi Painting, Inc. and Blizzard Snow & Ice Control, LLC; however, none of the wages for these companies were earned within 52 weeks prior to the alleged date of accident. *Id.* The paystubs from Coluzzi Painting covered May 11, 2006 through May 31, 2006 which was almost two years prior to the alleged work accident. *Id.* Likewise, the paystubs from Blizzard Snow & Ice Control covered January 10, 2013 through January 22, 2013, February 5, 2013 through February 20, 2013, and March 7, 2013 through December 16, 2013. *Id.* It is clear that the Blizzard Snow & Ice Control earnings were for work performed years after the alleged March 2008 work accident. Thus, these wages are not relevant to this case.

Petitioner testified that he severely injured his right leg and knee in a motorcycle accident in 1989 which resulted in at least six surgeries to repair damage to the leg and knee. Petitioner testified that he had metal plates inserted into his hip and knee as well.

Petitioner testified that on March 2, 2008, he was delivering papers on his assigned route at approximately 4 a.m. Petitioner testified that he slipped and fell on ice. Following his fall, Petitioner

crawled back to his vehicle, drove home, and iced his leg. Petitioner testified that he called Swift and told someone that he injured his right leg and was going to visit his doctor. Petitioner did not identify the person at Swift to whom he gave this notice of his injury. Petitioner testified that no one witnessed his fall.

Petitioner did not seek any medical treatment until March 4, 2008. (PX 2). Petitioner testified that he saw his primary care physician on that date. The medical records reflect that on March 4, 2008, Dr. Raghavendra prescribed an MRI of Petitioner's right knee to evaluate for a possible meniscal injury due to swelling and severe pain. *Id.* Petitioner apparently saw Dr. Raghavendra again on March 11, 2008, at St. James Hospital. *Id.* The hospital information sheet from that visit indicates the visit was regarding Petitioner's right knee injury due to a fall on ice. There is no mention of this injury being related in any way to Petitioner's employment. There are no other records pertaining to this visit. The Arbitrator notes that this information sheet identifies M Lizen Manufacturing located at 42 East 30th Place, Steger, IL 60475 as Petitioner's employer. There is no mention anywhere of Swift News Agency as Petitioner's employer.

Petitioner returned to St. James Hospital on March 12, 2008, for an MRI of his right leg. The MRI report notes that extensive metallic hardware limited evaluation of the MRI results. *Id.* The report indicates post-surgical changes of the proximal tibia which casts metallic susceptibility artifact limiting evaluation of the exam; an ACL tear; thickening and linear high signal within the PCL suggesting a partial tear; maceration of the lateral meniscus; severe fracture deformity of the fibular head as well as the lateral tibial plateau with no bony edema suggesting old fractures; mild degenerative changes; and mild high signal in the distal quadriceps tendon suggesting tendinopathy. *Id.* The medical records reflect that Petitioner did not seek any follow up care for this injury following the MRI until he visited Dr. Mehl at Specialty Physicians of Illinois, LLC in July of 2013. (PX 3). Petitioner testified that he did not seek any treatment for his injury between 2008 and his July 2013 visit with Dr. Mehl. Petitioner also testified that he did not participate in any physical therapy, did not receive any injections in his right leg or knee, and did not undergo any surgery following the March 2008 MRI. It appears Petitioner did not treat his injury at all other than the apparent two doctor visits in March 2008 and the March 2008 MRI exam. Thus, it is unclear what, if any, of the findings on the MRI are related specifically to his March 2 fall as there were several serious and chronic injuries reflected on the MRI. There are no medical records in evidence of any doctor reviewing the MRI report and making a determination as to which findings were chronic or pre-dated the March fall and which findings were acute and possibly the result of Petitioner's alleged fall. Although the examination notes from the July 2013 visit with Dr. Mehl are not in evidence, Petitioner did submit Dr. Mehl's November 20, 2013 narrative addressed to Petitioner's attorney and written at the request of this attorney. (PX 3). Dr. Mehl diagnosed Petitioner with severe posttraumatic right knee degenerative joint disease; however, he stated he could not "determine whether or not his work injury from March 2, 2008, aggravated the condition of his right knee" and could not "provide any opinions as to whether or not the work injury aggravated the condition of his right knee." *Id.* Dr. Mehl opined that since Petitioner suffered the tibial plateau fracture in 1989, "he would be at a high

risk to develop posttraumatic degenerative disease from that injury alone in 1989." *Id.* Dr. Mehl further determined that Petitioner's current condition of ill-being is severe posttraumatic degenerative joint disease and that Petitioner would need a total knee replacement. *Id.* Dr. Mehl referred Petitioner to Dr. Finn due to the complicated nature of the recommended surgery. *Id.* Petitioner has not undergone any surgery and has never seen Dr. Finn.

Petitioner testified he did not miss any assignments with Arctic Snow due to his injury. Petitioner testified that he returned to work at Swift within six weeks after the accident but his job duties were limited. Petitioner testified that he used crutches for the first month following the accident and wore a brace approximately six weeks post-accident. Petitioner testified Swift did not pay him any compensation during the six weeks he was off work and when he returned he received less pay because he could not perform some of his original work duties. Petitioner testified that he could not unload trucks or set up zip codes but he did drive his car for paper delivery with another employee who actually walked the papers to each property from the car. Petitioner testified that since his pay at Swift was always dependent upon the actual tasks he completed as opposed to hours worked he was only paid approximately $75.00 a week following his return to work after the accident. Petitioner presented no proof other than his testimony of this reduced wage. The Arbitrator notes that Petitioner submitted no off work slips and presented no medical records showing any doctor placed restrictions upon Petitioner's work duties following the accident. However, Petitioner testified that he did turn in off work slips to Barb, the secretary. Petitioner left his employment at Swift in June 2009.

Petitioner is currently unemployed but continues to plow snow in the winters. Petitioner testified that he also continues to paint windows as a side business.

Petitioner testified that his right knee is still in a lot of pain. Petitioner said that he is not able to pivot normally and he ices his knee occasionally. He also wraps his knee and takes Advil when needed. Petitioner testified that he did not have any problems with his right knee prior to the March 2, 2008 slip and fall and has suffered no injuries to the right leg since that time. Petitioner testified that following the March 2008 fall, his right leg felt "sloppy" and he had trouble walking. Petitioner testified that he is scared of having the knee replacement surgery due to the complicated nature of his condition, but is interested in learning more about his options. Petitioner is not currently taking any prescription pain medications and does not have any appointments scheduled with any medical professionals relating to the condition of his right knee.

Petitioner submitted a bill from Midwest Physician Group Ltd. (PX 4). Petitioner testified that Swift never paid any of his medical bills.

CONCLUSIONS OF LAW

The Arbitrator adopts the above findings of material facts in support of the following conclusions of law:

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

Petitioner testified that Swift News Agency prepared and delivered newspapers. Petitioner testified that trucks delivered papers and material and he had to use an electronic floor lift to move the materials from the trucks onto pallets and into the business. Petitioner also testified that he was responsible for delivering newspapers to various customers and drove a car to do so. Petitioner testified that there were other employees employed at Swift on the date of accident. The Arbitrator finds that Swift News Agency was subject to the automatic coverage provision of Section 3.3 and Section 3.15 of the Act.

B. Was there an employee-employer relationship?

The existence of an employment relationship is a prerequisite for any award of benefits under the Act. Petitioner testified that he began employment with Swift News Agency in April 2007. Petitioner testified that Swift took taxes out of each pay check and issued W2s to Petitioner. However, Petitioner presented no corroborating evidence that he was ever employed by Swift. This is especially troubling considering the only reference to employment in the relevant medical records indicates that he was employed by a different company, M Lizen Manufacturing. (PX 2). Petitioner submitted relevant paystubs from his other employer, Arctic Snow and Ice Control, Inc. (PX 1). Petitioner also submitted paystubs for earnings received almost two years prior to the alleged March 2008 accident from Coluzzi Painting, Inc. and paystubs for earnings received several years after the alleged accident from Blizzard Snow & Ice Control, LLC. *Id.* None of those earnings are relevant to this arbitration.

Petitioner submitted no paystubs, no bank statements, no W2s, or any other independent evidence that would corroborate his testimony of employment with Swift on March 2, 2008.

The Arbitrator also notes that even if Petitioner had proof that he ever worked for Swift, he did not prove that an employee-employer relationship existed. There is no specific litmus test for determining whether an employer-employee relationship exists. Rather, such a relationship, if one exists, must be inferred from the conduct of the parties. There are multiple factors to consider in assessing the nature of the relationship between the parties. *Ware v. Indus. Comm'n.*, 318 Ill. App. 3d 1117, 1122 (1st Dist. 2000). Among these are: (1) whether the employer may control the manner in which the person performs the work; (2) whether the employer dictates the person's schedule; (3) whether the employer pays the person hourly; (4) whether the employer withholds income and social security taxes from the person's compensation; (5) whether the employer may discharge the person at will; (6) whether the employer supplies the person with materials and equipment; and (7) whether the employer's general business encompasses the person's work. *See Roberson v. Indus. Comm'n.*, 866 NE.2d 191, 200 (Ill. 2007). Other relevant factors include the label the parties place on their relationship, and whether the parties' relationship was "long, continuous, and exclusive." *Ware*, 318

Ill. App. 3d at 1122, 1126. The right to control work is perhaps the primary factor in determining the existence of an employment relationship. However, no single factor is determinative and the significance of the factors changes depending on the type of work involved. The determination rests on the totality of the circumstances. *Roberson*, 866 NE.2d at 200.

Petitioner testified that he drove his own car when delivering papers. He did not present any evidence or testimony that Swift set his hours. Petitioner testified that he was paid only for the duties he completed, not on an hourly basis and Petitioner did not receive a salary. Petitioner testified that Swift withheld taxes from his paychecks; however, he presented no evidence of ever receiving any pay from Swift and presented no evidence that Swift did withhold taxes from his pay. Petitioner testified that there was no real supervision because once employees knew what duties to complete they were left alone to complete them. There is no evidence Swift controlled the exact manner in which Petitioner completed his duties. In fact, based on Petitioner's testimony it appears Swift did not particularly care about the manner in which each task was completed as long as Petitioner completed his tasks. Additionally, Petitioner's alleged employment with Swift was not exclusive as the records show that he also worked at Arctic Snow during his alleged employment with Swift.

Based on the foregoing, the Arbitrator finds that no employee-employer relationship existed between Swift and Petitioner. Therefore, no benefits are awarded to Petitioner.

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

The Arbitrator has already found that no employee-employer relationship existed between Swift News Agency and Petitioner. Thus, no benefits are awarded and the Arbitrator makes no findings in regards to whether an accident occurred that arose out of and in the course of Petitioner's employment.

D. What was the date of the accident?

The Arbitrator has already found that no employee-employer relationship existed between Swift News Agency and Petitioner. Thus, no benefits are awarded and the Arbitrator makes no findings in regards to the date of accident.

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

The Arbitrator has already found that no employee-employer relationship existed between Swift News Agency and Petitioner. Thus, no benefits are awarded and the Arbitrator makes no findings in regards to whether timely notice of the accident was given to Respondent.

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

The Arbitrator has already found that no employee-employer relationship existed between Swift News Agency and Petitioner. Thus, no benefits are awarded and the Arbitrator makes no findings in regards to whether Petitioner's current condition of ill-being is causally related to the injury.

G. What were Petitioner's earnings?

The Arbitrator has already found that no employee-employer relationship existed between Swift News Agency and Petitioner. Thus, no benefits are awarded and the Arbitrator makes no findings in regards to Petitioner's earnings.

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

The Arbitrator has already found that no employee-employer relationship existed between Swift News Agency and Petitioner. Thus, no benefits are awarded and the Arbitrator makes no findings in regards to Petitioner's age at the time of the accident.

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

The Arbitrator has already found that no employee-employer relationship existed between Swift News Agency and Petitioner. Thus, no benefits are awarded and the Arbitrator makes no findings in regards to 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?

The Arbitrator has already found that no employee-employer relationship existed between Swift News Agency and Petitioner. Thus, no benefits are awarded and the Arbitrator makes no findings in regards to medical services and charges.

K. What temporary benefits are in dispute?

The Arbitrator has already found that no employee-employer relationship existed between Swift News Agency and Petitioner. Thus, no benefits are awarded and the Arbitrator makes no findings in regards to temporary benefits.

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

The Arbitrator has already found that no employee-employer relationship existed between Swift News Agency and Petitioner. Thus, no benefits are awarded and the Arbitrator makes no findings in regards to the nature and extent of the injury.

O. Other: Insurance

The Arbitrator has already found that no employee-employer relationship existed between Swift News Agency and Petitioner. Thus, no benefits are awarded and the Arbitrator makes no findings in regards to whether Swift News Agency had workers' compensation insurance.

STATE OF ILLINOIS)
) SS.
COUNTY OF KANE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Maria Salgado,
Petitioner,
vs.

NO: 11WC 6946
15IWCC0043

Filtration Group, Inc.,
Respondent,

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 10, 2014, is hereby affirmed and adopted.

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

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

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: JAN 20 2015
o011515
DLG/jrc
045

David L. Gore

Mario Basurto

Stephen Mathis

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

SALGADO, MARIA
Employee/Petitioner

Case# **11WC006946**

FILTRATION GROUP INC
Employer/Respondent

15IWCC0043

On 7/10/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.06% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0293 KATZ FRIEDMAN EAGLE ET AL
MARIA BOCANEGRA
77 W WASHINGTON ST 20TH FL
CHICAGO, IL 60602

1120 BRADY CONNOLLY & MASUDA PC
JASON R STETZ
10 S LASALLE ST SUITE 900
CHICAGO, IL 60603

15IWCC0043

STATE OF ILLINOIS)
)SS.
COUNTY OF KANE)

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

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

Maria Salgado,
Employee/Petitioner

v.

Filtration Group, Inc.,
Employer/Respondent

Case # 11 WC 6946

Consolidated cases: none

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Peter M. O'Malley**, Arbitrator of the Commission, in the city of **Geneva**, on **4/15/14**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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 _____

15IWCC0043

FINDINGS

On the date of accident, **2/17/11**, 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 ***is not*** causally related to the accident.

In the year preceding the injury, Petitioner earned **$18,200.00**; the average weekly wage was **$350.00**.

On the date of accident, Petitioner was **43** 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 **$32,563.14** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$0.00** for other benefits, for a total credit of **$32,563.14**.

Respondent is entitled to a credit of **$29,172.05** under Section 8(j) of the Act. (See Arb.Ex.#2).

ORDER

The Arbitrator finds that Petitioner failed to prove by a preponderance of the evidence that she sustained accidental injuries arising out of and in the course of her employment on February 17, 2011 and failed to prove that her current condition of ill-being is causally related to said alleged accident. Accordingly, Petitioner's claim for compensation is hereby denied.

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.

Signature of Arbitrator

6/18/14
Date

ICArbDec19(b)

JUL 10 2014

15IWCC0043

STATEMENT OF FACTS:

Petitioner, a 43 year old filter assembly line worker, testified that she began working for Respondent in March of 2007. She indicated that her initial assignment was in the area with Sagrario Martinez assembling filters. As part of her job, the materials were found inside a box and petitioner would take them to an assembling table. She would take measurements and would take the frame, which was already cut, and assemble the filter. Assembly would involve the petitioner holding the frame with both hands and bending it. She would then take a stapler and staple in all four places and would place a metal plate inside the frame. Petitioner would then take the filter and fit it inside the frame. This process would take more or less one minute, depending upon the size of the filter. Petitioner testified that the smallest filter she worked with was 10" x 10" and the largest one was 6" x 30". The filters would weigh approximately 10 oz. to 1 lb., depending upon the size. Petitioner testified that she worked in this area for approximately three years. During her time at Filtration Group, petitioner would work 10 hours a day over four days per week. On cross-examination petitioner testified that the work surface she utilized at Filtration Group came to approximately waist level. She testified that the staple gun or stapler that she used was located on the desk top and that the glue gun that she used was approximately one foot above the table top surface. Petitioner indicated that she stands 5'1" tall.

Sometime in January of 2010 petitioner was moved to an area that was supervised by Jessica Servantes. Petitioner testified that in Jessica's area the filter would come from a machine already made. Petitioner would need to size the filters and would have to add the frame to the filter itself. In order to assemble a filter in Jessica's area, petitioner testified that she would place the filter within the frame and would staple the corners of the frame. She would also use a glue gun. Assembly of filters in Jessica's area would take between three and five minutes. She testified that while working in Jessica's area, her arms would be elevated approximately 80% of the time below shoulder level. Petitioner testified that she would do some above shoulder level work when boxes would need to be cut to size to fit filters. This activity would be required in less than half of the filters that petitioner assembled and the cutting process itself would occur less than half of that time.

Petitioner testified that after working in Jessica's area for approximately a month her shoulders began to hurt. She testified that she spoke with Sagrario and asked to be moved back to her prior work area due to her pain. She indicated that she was not moved at that time. Petitioner also testified that she complained of shoulder pain to her human resources representative, Maribel Guel. Petitioner noted that an accident report was not prepared at that time. She was also not aware of any investigation and was not offered any medical attention.

On the date of the alleged accident, February 17, 2011, petitioner was working in Jessica's area. She noted that she began work at 5:00 a.m. and that before the first break at 7:45 am she felt pain very strongly in her shoulders and back as she grabbed a box from the floor and was bringing it to the packing table. She indicated that the box she lifted on weighed between 12 and 15 lbs. Petitioner testified on direct examination that after this occurrence she knew she would not be switched from Jessica's area, so she gathered her things and went home to take a pill for pain. When asked by her attorney whether she spoke to anyone before she went home, Petitioner indicated that she did not, and that she also did not punch out. However, on cross examination, Petitioner testified that she spoke to Maribel Guel in HR on the February 17, 2011 and reported the accident. She also noted that she had spoken to Ms. Guel on February 7, 2011 and/or February 10, 2011 and told her that the new area was more work and was hurting her shoulders, and that she asked to go back to her prior work area.

Petitioner testified that she did not work the day after the alleged accident, Friday February 18, 2011, since she did not work Fridays. She indicated that she did not call work on that date. Petitioner testified that she later called and spoke to Maribel after she went to the doctor to see if she could get her job back. Petitioner testified

that she was not accepted back at that time. She agreed that she did not speak to anyone about trying to make an incident report or accident report at that or any time thereafter.

Petitioner made an appointment to see Dr. Mark Cohen and was eventually seen on February 23, 2011. (PX3, p.2). Dr. Cohen noted present complaints including right elbow, right shoulder, low back, mid back, left shoulder, left arm, left wrist, neck pain and right leg tingling. Dr. Cohen noted a history that on February 17, 2011 the petitioner was working when she lifted a large filter. He also noted that while bending over, she felt an onset of pain in the low back and bilateral upper extremities. Dr. Cohen recorded that Petitioner finished working the rest of the day but that her pain got progressively worse and she was unable to work. Petitioner was diagnosed at that time with neck pain, mid back pain, low back pain and bilateral shoulder pain. (PX3, p.4). Dr. Cohen ordered MRIs to rule out herniated nucleus pulposus as well as bilateral shoulder internal derangement. Petitioner was noted to be unable to return to work for 14 days. (PX3, p.8).

Petitioner testified that after starting treatment she would receive work restriction reports from her doctors but did not bring them to work. She indicated she would speak with Maribel on the phone regarding the restrictions. She also noted that she filed for unemployment. She denied stated that she was fired or quit but claimed that she informed the unemployment office that she was hurt on the job.

On March 9, 2011 petitioner was seen for consultation by Dr. Ernesto Padron. (PX4, p.26). Petitioner presented with complaints of bilateral shoulder pain, neck pain and low back pain with radiculopathy, right greater than left, as well as right elbow pain. Dr. Padron noted a history of an initial injury of the right wrist resulting in surgery and no type of flexion or extension of the wrist. Dr. Padron opined that petitioner's work place knew of this injury but still placed her in a position where she had to perform normal duties. He indicated it was difficult for the petitioner to perform her duties as she had to use her arms and wrists repeatedly using repetitive motions all day long. Instead of using her wrist to move things, petitioner would move her whole shoulder or push with her shoulders or her neck. The doctor noted that petitioner also had been complaining of low back pain as well as neck pain. On February 24, 2011 petitioner was lifting some materials and felt a pop in her low back resulting in a radiation into the left lower extremity. The neck pain happened around the same time, but this was more secondary to petitioner having to favor her right wrist. After physical examination and review of MRI films, Dr. Padron noted that petitioner has positive findings in MRI although her pain appeared to be sacroiliitis by physical examination. (PX3, p.27). Dr. Padron recommended bilateral SI joint injections. On March 23, 2011 petitioner followed up with Dr. Padron. (PX4, p.20). Petitioner had undergone sacroiliac joint injections approximately two weeks prior. She reported 50% improvement. At that time, Dr. Padron recommended repeat SI joint injections.

On April 12, 2011 petitioner underwent EMG testing with chiropractor Dr. Carlos Halwaji. (PX5, p.2). Petitioner presented with complaints of pain in the neck and mid and low back with pain and numbness and tingling into her arms and right leg. She reported that on February 17, 2011 she was at work when she lifted a heavy filter and symptoms began. Testing was conducted and Dr. Halwaji noted impression of findings that revealed a neuropathy affecting the C5 to T1 to a greater degree on the left. (PX5, p.3). Dr. Halwaji recommended continuing with current treatment of physical therapy, chiropractic rehabilitation and prescribed medication.

On May 6, 2011 the petitioner was seen by Dr. Blair Rhode at Orland Park Orthopedics for a consultation regarding bilateral shoulder pain, low back pain and neck pain. (PX7, p.5). Petitioner gave a history of suffering an injury on February 17, 2011 when she lifted a large box awkwardly. Petitioner also stated she had been recently moved to a new department for which she was required to perform a highly repetitive action of assembling a filter, placing it in a box and taping and moving it. This was a new position which she performed

for two weeks. Dr. Rhode assessed petitioner with bilateral rotator cuff tendonitis and cervical strain. (PX7, p.6). Dr. Rhode recommended a conservative course with an attempted injection, home cuff exercises and continued chiropractic treatment. The doctor noted that petitioner should be off work. (PX7, p.7).

On May 27, 2011 petitioner followed up with Dr. Blair Rhode with complaints of bilateral shoulder pain, low back pain and neck pain. (PX7, p.8). Petitioner was again diagnosed with bilateral rotator cuff tendonitis and cervical strain. (PX7, p.9). The doctor noted that petitioner sustained her injury due to a repetitive new position of assembling filters and packaging them. She also sustained a single event of an awkward lifting of a large box. Conservative care was recommended with an attempted injection, home cuff exercises and continued chiropractic treatment. Petitioner followed up with Dr. Rhode on July 29, 2011 with continued complaints of bilateral shoulder pain, low back pain and neck pain. (PX7, p.10). The doctor noted that petitioner was responding to therapy. Dr. Rhode again assessed the petitioner with bilateral rotator cuff tendonitis and cervical strain. (PX7, p.11). He recommended attempting a second subacromial injection and continued therapy.

On October 14, 2011 petitioner presented for follow-up with Dr. Blair Rhode regarding bilateral shoulder pain, low back pain and neck pain. (PX7, p.15). Symptoms were noted to be secondary to an injury while at work. Petitioner was noted to be status post bilateral injection with temporary relief. The doctor opined that petitioner's shoulders were her primary pain generator. The doctor also noted that petitioner had undergone bilateral shoulder MRIs which revealed intact cuffs. His assessment at that time was shoulder pain, neck pain, and rotator cuff strain. Dr. Rhode noted that repeat injections had failed. (PX7, p.16). He recommended formal physical therapy. Petitioner was to remain off work. (PX7, p.17).

On December 21, 2011 petitioner presented for follow-up with Dr. Blair Rhode. (PX7, p.21). Dr. Rhode noted that petitioner had sustained a work-related bilateral shoulder, neck and low back injury on February 17, 2011 when she lifted a large box awkwardly. He noted that petitioner also performed a highly repetitive job and had a fusion on her right wrist. This required her to use both arms. Petitioner used a glue gun and stabilized with her left. The doctor noted that petitioner was frequently required to waist to crown and above shoulder lift. She continued with severe shoulder pain. Dr. Rhode noted that petitioner demonstrated bilateral rotator cuff tendonitis with cervical strain. (PX7, p.22). He recommended proceeding with an MRI of both shoulders and noted that petitioner is to be off duty.

On January 6, 2012 petitioner presented for follow-up with Dr. Blair Rhode regarding bilateral shoulder pain, low back pain and neck pain. (PX7, p.26). Petitioner presented status post bilateral MRI. The report notes that petitioner had undergone an MRI of both shoulders and that there was no rotator cuff tear. Dr. Rhode indicated that petitioner demonstrated bilateral rotator cuff tendonitis with AC pain. (PX7, p.27). Petitioner is to be off work and the doctor discussed an AC injection. The doctor recommended continuing with therapy.

On February 3, 2012 petitioner presented for follow-up with Dr. Blair Rhode regarding bilateral shoulder pain, low back pain and neck pain. (PX7, p.29). Dr. Rhode noted that petitioner sustained a work-related bilateral shoulder, neck and low back injury on February 17, 2011 when she lifted a large box awkwardly. Petitioner was noted to be status post IME. Dr. Rhode noted that petitioner demonstrated bilateral rotator cuff tendonitis and AC pain. (PX7, p.30). She was off duty and the doctor discussed an AC injection. He further discussed with petitioner that her options would be to live with her condition, undergo injections or undergo surgery. Petitioner indicated that she was unwilling to live with her current symptoms and wished to proceed with surgery. Risks were discussed and petitioner understood and wished to proceed.

On March 22, 2012 petitioner was seen by Dr. Kevin Tu at G&T Orthopedics and Sports Medicine for history and examination. (PX10, p.9). Petitioner was noted to be complaining of bilateral shoulder pain after a work

injury on February 17, 2011. She worked as an assembler for filters. She indicated she assembled approximately 10 to 12 filters per hour at the waist level. She used a glue gun and had to guide filters down an assembly line. Since her injury, she had difficulty with daily and work activities. Petitioner had undergone a course of physical therapy with improvement of her symptoms. She underwent four shoulder injections with no improvement of her symptoms. She also had two back injections with no improvement of her symptoms. After physical examination Dr. Tu opined that petitioner's symptoms were not from her shoulder. He indicated that petitioner had had treatment, including shoulder injections with minimal improvement of symptoms. Dr. Tu recommended a referral to a pain specialist for evaluation and treatment.

On April 10, 2012 petitioner was seen by Dr. Scott Glaser at Pain & Rehab Specialists of Greater Chicago for a history and physical. (PX11, p.3). Petitioner presented with complaints of bilateral shoulder pain and bilateral arm pain. The onset was noted to be sudden. Pain began one year prior. Petitioner's neck pain, radiating arm pain and right lower back pain started when she was working as an assembler. She was switched to a new job and the repetitive job of assembling filters caused her pain to develop. The pain became so severe after lifting one heavy filter on February 17 that she could not work anymore. Petitioner also complained of low back pain which began one year prior. After physical examination, Dr. Glaser diagnosed petitioner with cervical radiculopathy, shoulder pain and facet syndrome without myelopathy at the cervical and lumbar areas. (PX11, p.6). Lidoderm patches were recommended and petitioner was instructed to follow up in one week's time. (PX11, p.7).

On May 1, 2012 petitioner presented for follow-up with Dr. Glaser. (PX11, p.11). Petitioner indicated that her bilateral lower back pain had stayed the same since her last visit. Petitioner's bilateral shoulder blade pain had stayed the same as well. After physical examination, Dr. Glaser recommended that petitioner undergo a physical therapy evaluation and follow up in one month's time. (PX11, p.12).

On May 31, 2012 petitioner followed up at G&T Orthopedics and Sports Medicine. (PX10, p.11). Petitioner indicated she had been seeing pain management with minimal improvement of symptoms. After physical examination, the assessment was noted to be pain in the shoulder region. It was noted that petitioner had failed conservative treatment and had multiple cortisone injections and physical therapy with minimal improvement of symptoms. Petitioner indicated she would like to proceed with surgery with Dr. Rhode. She was to return on an as needed basis.

On July 31, 2012 petitioner underwent surgery with Dr. Blair Rhode. (PX7, p.41). The procedure involved a left shoulder subacromial decompression and arthroscopic rotator cuff repair.

On November 30, 2012 petitioner followed up with Dr. Rhode and indicated that her right shoulder was increasingly aggravated. (PX7, p.57). Dr. Rhode noted that petitioner was status post surgery. (PX7, p.58). He recommended continuing therapy and allow modified duty. Petitioner continued with significant right shoulder symptoms and another injection was discussed. Dr. Rhode noted that petitioner was able to return to work at light duty with modified restrictions regarding the left shoulder of no lifting greater than 10 lbs. maximum or 5 lbs. frequently. (PX7, p.59).

On December 28, 2012 petitioner followed up with Dr. Rhode. (PX7, p.61). Dr. Rhode noted that petitioner was status post surgery and she continued with significant right shoulder symptoms. Petitioner was unwilling to live with the symptoms on the right shoulder and the doctor recommended proceeding with an arthroscopic intervention to the right. Risks and benefits were discussed and the petitioner indicated she wished to proceed.

On May 3, 2013 petitioner was seen by Dr. Rhode for follow-up of left shoulder arthroscopy. (PX7, p.64). Petitioner stated that her right shoulder was increasingly aggravated and reiterated her work exposure. Petitioner indicated she performed the duty of assembler for four years. She worked 10 hours per day for four days per week. Petitioner indicated she lifted air conditioner filters 24x24x4 inches. She would place them in the air conditioning unit. She would then glue circumferentially around the unit. The table that petitioner worked on was waist high. The air conditioner unit on the table was up to crown level. Petitioner was noted to be 5'1" tall. The glue gun was noted to come from the ceiling. The doctor noted that petitioner reported her bilateral shoulder pain to human resources approximately one month prior to her injury. Human resources told petitioner that there was no problem and to go back to work. Petitioner was then moved to another department and the accident happened.

Dr. Rhode opined that petitioner had exhausted conservative measures and that it was appropriate to proceed with surgical intervention in the form of an arthroscopic subacromial decompression and possible rotator cuff repair. (PX7, p.65). Dr. Rhode noted that he had the opportunity to review the §12 report of Dr. Verma. Dr. Verma described a job exposure which was performed at waist level with minimal weight. Dr. Rhode noted that he again had a discussion at length relative to petitioner's job exposure. The petitioner's job exposure included four years of exposure for 40 hours per week. She was required to prepare air conditioners and filters. She described a motion that she was required to insert the filters as well as operate a glue gun in a waist to crown motion. The glue gun was suspended from the ceiling. Petitioner was 5'1" tall and therefore would be more prone to crown level work. The petitioner also sustained a single event injury when she was lifting an object awkwardly. Dr. Rhode opined that this level of exposure caused petitioner's bilateral rotator cuff pathology based on the high repetition and lever mechanics. He noted that the rotator cuff is dependent upon both level of forward elevation and abduction as well as level length specifically how far away from the body one operates.

Petitioner's husband, Aristeo Salgado, testified that he has been employed at Filtration Group for seven years as a machine operator. Mr. Salgado indicated that his job is located in another department and on a different floor than his wife. He noted he had had the opportunity to observe the location where his wife works. However, he never observed his wife working given that they work on different shifts. In addition, Mr. Salgado testified that he did not speak to his wife on the date of the alleged accident, February 27, 2011 but that the following day his wife informed him that her arms and back were hurting.

Respondent's H.R administrator, Maribel Guel, testified that she worked for Filtration Group for 10 years and that her duties included employee relations and family medical leave. She also noted that she was the person who reported all workers' compensation injuries to the correct parties within Filtration Group. Ms. Guel testified that on February 7, 2011 she had the opportunity to speak to petitioner's supervisor, Martha Pedersen. Based upon this conversation, it was Ms. Guel's understanding that the petitioner expressed a concern to Ms. Pedersen that she wished to return to Sagrario's area from which she had been recently moved. Ms. Guel testified that the reason for moving petitioner from Sagrario's area to Jessica's area was due to a need for more workers in Jessica's area. Ms. Guel testified that on February 7, 2011 she also had the opportunity to speak to the petitioner herself. Ms. Guel testified that petitioner came to her office at approximately 12:30 p.m. and stated that she wished to move back to Sagrario's area. Petitioner informed Ms. Guel that she did not like working in the area with Jessica as the filters were more tedious and required more work. In response, Ms. Guel informed the petitioner that the employees were moved to areas depending on work needs and that petitioner would need to remain in Jessica's area.

Ms. Guel testified that she again had the opportunity to speak to the petitioner on February 10, 2011. The petitioner wished to know how long her supervisor Martha would keep her in Jessica's area. Ms. Guel informed the petitioner that she did not know how long petitioner would need to remain in Jessica's area and could not

provide a specific time frame as to when she might be returned to Sagrario's area. Ms. Guel again reminded petitioner that the employees were basically placed where they were needed based on the departmental needs and petitioner returned to her work area. Ms. Guel had the opportunity again to speak to the petitioner on February 17, 2011. The petitioner informed Ms. Guel that she did not like her job assignment in Jessica's area and had decided to resign her position. Ms. Guel inquired as to why petitioner was resigning and petitioner stated she just didn't like the area and walked out of the office. Ms. Guel testified that petitioner did not indicate to her that she wished to move departments due to being in pain or suffering an accident.

Ms. Guel testified that approximately two weeks later on March 1, 2011 she received a call from the petitioner. Petitioner wanted to know if there was any way she could have her job back. Petitioner told Ms. Guel that she had made a hasty decision and she would like to have her job back regardless of which department she was placed in. Ms. Guel informed her that Filtration Group would stick with their decision of accepting petitioner's resignation effective February 17, 2011. Ms. Guel testified that at no time between February 7, 2011 and February 17, 2011 did the petitioner indicate that she was injured or in pain. Ms. Guel testified that she received a report dated April 27, 2011 from the Illinois Department of Employment Security which reflected that the petitioner had quit her position.

Sagrario Martinez testified that she had been employed by Filtration Group for 23 years and that her current title was lead person. She noted that her job responsibilities included making filters and that she worked alongside the petitioner both in Jessica's area as well as her own area. Ms. Martinez testified that she would move between areas based on production needs. Ms. Martinez testified that the major difference between her area and Jessica's area is that her area did not have glue guns. Ms. Martinez testified that the table depicted in the photographs (RX5a-c) is the same height as that which the petitioner worked at. Ms. Martinez testified that she was 5'2" tall. Ms. Martinez also testified that petitioner never told her that her shoulders were hurting her. On re-direct, Ms. Martinez testified that the glue guns hung from a cord, but did rest on the table. She also testified that she was uncertain of the date that the photographs were taken, but re-confirmed that the work station depicted in Respondent's Exhibit #5, letters A through C, accurately depicted the work area as it was on February 17, 2011.

Warehouse supervisor Martha Pedersen testified that she was employed at Filtration Group and had been there for eight years. As part of her job duties Ms. Pedersen took care of the shipping end of the company and also supervised the workers themselves, including Maria Salgado. Ms. Pedersen testified that she was familiar with the difference between Sagrario's section and Jessica's section and that petitioner was moved based on production needs. Ms. Petersen testified that she was working at Filtration Group on February 17, 2011 and that petitioner did not come to her to indicate that she had suffered an injury while at work. She further testified that at no time in February of 2011 did the petitioner approach her and indicate she was having any pain. Ms. Pedersen noted that petitioner did approach her in February of 2011 and asked to be moved to a different section as she did not like the department that she was placed in. Ms. Pedersen again testified that petitioner did not indicate she was suffering any pain from working in the new area.

Petitioner was recalled to the witness stand and shown Respondent Exhibit #5, letters A through C. The petitioner testified that the pictures did not accurately depict her work station as the table she was working on was higher than that shown in the photographs. Petitioner also testified that when she was working, the glue gun would not rest on the table, but rather hung at a height. Petitioner again reiterated that she had complained to Sagrario Martinez and Maribel Guel regarding her shoulders. She also testified that the work in Jessica's area was more difficult.

WITH RESPECT TO ISSUES (C), DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF THE PETITIONER'S EMPLOYMENT BY THE RESPONDENT, AND (D), WHAT WAS THE DATE OF THE ACCIDENT, THE ARBITRATOR FINDS AS FOLLOWS:

It appears that Petitioner is proposing two possible theories of recovery in this case – one based on a claim that she suffered a single, identifiable traumatic event on February 17, 2011 and the other based on a claim that she suffered repetitive trauma type injuries to her shoulders and back as a result of her work activities and that said injuries manifested themselves on February 17, 2011.

With respect to the first theory of recovery, Petitioner testified that on February 17, 2011 she grabbed a box of filters from the floor and was bringing it to the packing table when she felt a strong pain in her shoulders and back. On direct examination she testified that she then gathered her things and went home to take a pain pill, and that she left work that day without speaking to anyone or punching out because she knew they would not change her job. On cross examination Petitioner claimed that she reported the incident to Maribel Guel on the date of the alleged accident. She also denied that she told Ms. Guel she was resigning her position on that date.

In contrast, Ms. Guel testified that on February 17, 2011 Petitioner approached her around break time, thanked her for the job and indicated that she just didn't like it and had decided to resign. Ms. Guel also stated that Petitioner did not report an injury to her or claim to be in pain at that time. In addition, Ms. Guel testified that on March 1, 2011 she received a call from Petitioner wherein Ms. Salgado indicated that she had made a hasty decision and would work wherever they wanted her. Ms. Guel indicated that she informed Petitioner at that time that they would stick to their decision and accept her resignation.

In addition, Sagrario Martinez, a lead person in the area where Petitioner originally worked, testified that Petitioner did not report an injury to her on the date of the alleged accident, February 17, 2011. Likewise, warehouse supervisor Martha Pedersen testified that she did not recall Petitioner telling her that she had hurt herself at work or was in pain on the date of the alleged accident. Instead, Ms. Pedersen indicated that Petitioner informed her on that date that she did not like the area where she had been placed and wanted to be moved to a different station.

Petitioner provided the following histories of accident to her treating physicians:

- On February 23, 2011, Dr. Mark Cohen recorded that Petitioner was bending over to lift a large filter. (PX3, p.2).
- On March 9, 2011, Dr. Ernesto Padron recorded that Petitioner was lifting some materials. (PX4, p.26).
- On April 12, 2011, chiropractor Dr. Carlos Halwaji recorded that she was lifting a heavy filter. (PX5, p.2).
- On May 6, 2011, Dr. Blair Rhode recorded that she lifted a large box awkwardly and performed a highly repetitive action of assembling a filter. (PX7, p.5).
- On April 10, 2012, Dr. Scott Glaser recorded that she was lifting one heavy filter. (PX11, p.3).

- On May 3, 2013, Dr. Rhode recorded that Petitioner was lifting air conditioner filters and installing them in an air conditioning unit. (PX7, p.64).

Petitioner also underwent two §12 examinations and provided a history of accident to each doctor as follows:

- On January 31, 2012, Dr. Jeffrey Coe recorded that Petitioner was carrying out customary filter assembly work requiring cutting of frames, gluing of assemblies and packaging of assembled filters. (RX4, p.2).

- On March 27, 2013, Dr. Nikhil Verma recorded that Petitioner was assembling filters while in standing position at table top level, that filters weighed between 2 and 5 lbs, that Petitioner placed finished filters in a box and moved them to a pallet requiring her to lift from floor to waist level, and that Petitioner denied any specific history of injury or trauma resulting in the onset of symptoms but rather reported gradual onset of symptoms over the period of one year. (RX3, pp.1-2).

With respect to Petitioner's repetitive trauma claim, Petitioner testified that her job duties with respondent involved the assembly of filters. She noted that her initial assignment was in Sagrario Martinez's area. As part of her job she would take measurements and would take the frame, which was already cut, and assemble the filter on an assembly table. Assembly would involve the petitioner holding the frame with both hands and bending it. She would then take a stapler and staple in all four places and would place a metal plate inside the frame. Petitioner would then take the filter and fit it inside the frame. This process would take one minute more or less depending on the size of the filter. Petitioner testified that the smallest filter she worked with was 10" x 10" and the largest one was 6" x 30". The filters would weigh approximately 10 oz. to 1 lb., depending on the size. Petitioner testified that she worked in this area ten hours a day, four days a week for approximately three years. On cross-examination petitioner testified that the work surface she utilized came to approximately waist level. She testified that the staple gun or stapler that she used was located on the desk top and that the glue gun that she used was approximately one foot above the table top surface. Petitioner indicated that she stands 5'1" tall.

Sometime in January of 2010 petitioner was moved to an area that was supervised by Jessica Servantes. Petitioner testified that in Jessica's area the filter would come from a machine already made. Petitioner would need to size the filters and would have to add the frame to the filter itself. In order to assemble a filter in Jessica's area, petitioner testified that she would place the filter within the frame and would staple the corners of the frame. She would also use a glue gun. Assembly of filters in Jessica's area would take between three and five minutes. She testified that while working in Jessica's area, her arms would be elevated approximately 80% of the time below shoulder level. Petitioner testified that she would do some above shoulder level work when boxes would need to be cut to size to fit filters. This activity would be required in less than half of the filters that petitioner assembled and the cutting process itself would occur less than half of that time.

Petitioner testified that sometime in January of 2010 she was moved to an area supervised by Jessica Servantes. Petitioner testified that in Jessica's area the filter would come from a machine already made and she would only need to size filters and add the frame to the filter itself. Petitioner testified that she would place the filter within the frame and staple the corners and use a glue gun to assemble the filters. Assembly of filters in Jessica's area would take between three and five minutes. After approximately a month in Jessica's area, petitioner testified that her shoulders began to hurt.

Lead worker Ms. Martinez testified that she would also worked in Jessica's area when they needed her – like on the date of the alleged accident when Petitioner left work -- and that the filters in that area were just as big as in

hers, only they required less work to assemble in Jessica's area. Ms. Martinez was also shown photos of the work space in Jessica's area. (RX5a-c). Ms. Martinez indicated that the photos show her assembling a filter at a typical work station. She agreed that the work station in Jessica's area had glue guns while her area did not. She also agreed that the glue gun in Jessica's area was adjustable in that it was suspended from a pulley system from the ceiling and the gun rested on the table. Ms. Martinez also stated that she assembled larger filters in her area and that to construct a filter you would cut the filter to size, attach with tape and use a glue gun at the end. Ms. Martinez noted that she is 5'2" tall and that the assembly table in question was at the same level for her as for Petitioner.

Warehouse supervisor Martha Pederson testified that while the filters in both areas weighed the same, the filters in Jessica's section were smaller since the pleats were already cut. In addition, she indicated that the glue gun was on the table and filters were made at waist level. As a result, Ms. Pederson noted that there would be no reason for work to be done overhead, although she did concede that the job was repetitive and required that her arms to be in front of her. She indicated that once the filters were assembled they were boxed and placed on a skid. She noted that the weight of the box would depend on the filters, but would that a box would weigh less than 10 pounds given each filter weighed less than a pound and there were 12 filters to a box.

Based on the above, and the record taken as whole, the Arbitrator finds that Petitioner failed to prove by a preponderance of the credible evidence that she sustained accidental injuries arising out of and in the course of her employment, either as a single traumatic event or as a result of repetitive trauma. More to the point, the Arbitrator did not find Petitioner's testimony as to the circumstances surrounding the alleged accident on the date in question to be credible, based on the testimony of Ms. Martinez, Ms. Guel and Ms. Pedersen. In fact, it would appear that Petitioner's concerns on the date in question had more to do with her dissatisfaction with her new work area than any claimed injury. Furthermore, the Arbitrator is not convinced that the activity performed by Petitioner in either work area, in terms of the positioning of her arms, was sufficient enough to result in her claimed bilateral shoulder and back conditions based on a theory of repetitive trauma. Specifically, the Arbitrator notes that the task of assembling the filters in question, while repetitive in nature, does not appear to have required the use of one's arms above shoulder height, even for a person of Petitioner's stature, based on the photos of the work station as well as the credible testimony of Ms. Martinez, Ms. Guel and Ms. Pedersen. Therefore, Petitioner's claim for compensation is hereby denied.

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

Petitioner initially testified on direct examination that she left on February 17, 2011 due to pain to go home and take a pain pill. She testified that she did not let anyone know she was leaving and did not punch out. Witnesses Maribel Guel, Sagrario Martinez and Martha Pedersen all testified that petitioner never indicated she was in pain, nor did she report an accident that occurred on February 17, 2011. However, on cross-examination, petitioner testified that she did speak with Maribel Guel on February 17, 2011 and reported that she had an accident that day.

Petitioner submitted into evidence an Application for Adjustment of Claim filed on February 24, 2011 reflecting a date of accident of February 7, 2011. (PX2). A later Amended Application for Adjustment of Claim reflecting a date of accident of February 17, 2011 was filed on November 13, 2013. (PX1).

Based upon the filing date of petitioner's initial Application for Adjustment of Claim, the Arbitrator finds that the petitioner has satisfied the notice requirement.

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

Petitioner testified that her job duties with respondent were to assemble filters. Her initial assignment was in the area with Sagrario Martinez. In this area, petitioner would assemble the filter material with the frame using a stapler. Petitioner testified that she worked in this area for approximately three years, working 10 hours a day over four days a week.

Sometime in January of 2010, the petitioner testified that she was moved to an area supervised by Jessica Servantes. Petitioner testified that in Jessica's area the filter would come from a machine already made and she would only need to size filters and add the frame to the filter itself. Petitioner testified that she would place the filter within the frame and staple the corners and use a glue gun to assemble the filters. Assembly of filters in Jessica's area would take between three and five minutes. Petitioner testified after approximately a month in Jessica's area her shoulders began to hurt.

On February 17, 2011 the petitioner testified that she was working in Jessica's area and was feeling pain very strongly in her shoulders and back. She testified that she was carrying a box of filters and felt pain strongly in her shoulders and back.

Petitioner's surgeon, Dr. Rhode, testified that petitioner provided a history of lifting air conditioner filters that were 24" x 24" x 4". (PX12, p.36). He testified that his understanding was that Petitioner would place the filters in an air conditioning unit and then glue circumferentially around the unit. (PX12, p.36). The air conditioner unit on the table was up to crown level and the glue gun came down from the ceiling. (PX12, p.36). Dr. Rhode further testified that the air conditioning unit was at crown level and as the petitioner was required to glue circumferentially around the unit, her arms would be at crown level. (PX12, p.38). However, Dr. Rhode indicated that he did not know how far above petitioner's head the glue gun would hang. (PX12, p.38-39). Dr. Rhode also noted that "[t]his is a dose response type injury, and the primary exposure relative to the repetitive exposure would have been the assembly … and I believe both exposures [placing filters in boxes and taping as well as placing filters on air-conditioners and gluing] are appropriate, but he dose, meaning how many repetitions she performed, was primarily the assembly of the filter within the air conditioning unit." (PX12, p.41). Dr. Rhode was also under the impression that Petitioner had performed these duties for four years, ten hours a day, four days a week. (PX12, pp.40-41)

Respondent's §12 examining physician, Dr. Verma, testified that Petitioner worked in a standing position at table top level and that the work was done at waist level assembling filters between 2 and 5 lbs. (RX2, pp.7-8). Petitioner would then move completed filters to a box and subsequently to a pallet. He noted that Petitioner indicated that she was required to lift boxes from the floor to waist level, working approximately 10 hours per day. Dr. Verma testified that based upon the description given to him by petitioner, she would have worked essentially at waist level 70% to 80% of her work day. (RX2, p.21). Dr. Verma noted that he understood that the majority of petitioner's work would have been with her arms extended, but opined that this type of work would not have caused a shoulder impingement or rotator cuff tear. (RX2, p.23). Dr. Verma noted that studies show that repetitive overhead work on a frequent basis greater than 50% of the work day has been associated with shoulder pain. (RX2, p.25). However, he noted there were no studies showing that work at waist level or below shoulder level even on a repetitive basis resulted in shoulder impingement and/or rotator cuff tears. (RX2, pp.25-26). Dr. Verma also noted that there was no scientific basis that repetitive work below shoulder level resulted in shoulder impingement. (RX2, p.27). In addition, Dr. Verma stated that with respect to the right shoulder, he did not see any evidence of significant rotator cuff tear; however, he did note degenerative findings

that likely pre-dated the onset of symptoms. (RX2, pp.29-30). Dr. Verma opined that these degenerative conditions were not aggravated by petitioner's work activities. (RX2, p.30).

Based on the above, and the record taken as a whole, and in light of the Arbitrator's finding as to accident (issue "C", supra), the Arbitrator finds that Petitioner failed to prove by a preponderance of the credible evidence that her current conditions of ill-being with respect to her bilateral shoulders and back are causally related to the alleged accident on February 17, 2011. Along these lines, the Arbitrator finds the opinions of Dr. Verma to be more persuasive than those offered by Dr. Rhode, particularly in light of the fact that Dr. Rhode's opinion appears to be based not only on the repetitive nature of the work but also his misunderstanding that the work was at crown level. As previously mentioned, the Arbitrator is not convinced that this was the case, given the photos of the work station as well as the credible testimony of Ms. Martinez, Ms. Guel and Ms. Pedersen. Therefore, Petitioner's claim for compensation is hereby denied.

WITH RESPECT TO ISSUE (J), WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY AND HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES, THE ARBITRATOR FINDS AS FOLLOWS:

Based on the above, and the record taken as a whole, and in light of the Arbitrator's determination as to accident and causation (issues "C" and "F", supra), the Arbitrator finds that Petitioner failed to prove her entitlement to medical expenses pursuant to §8(a) of the Act. Accordingly, Petitioner's claim for same is hereby denied.

WITH RESPECT TO ISSUE (K), IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE, THE ARBITRATOR FINDS AS FOLLOWS:

Based on the above, and the record taken as a whole, and in light of the Arbitrator's determination as to accident and causation (issues "C" and "F", supra), the Arbitrator finds that Petitioner failed to prove her entitlement to prospective medical care and treatment pursuant to §8(a) of the Act. Accordingly, Petitioner's claim for same is hereby denied.

WITH RESPECT TO ISSUE (L), WHAT AMOUNT OF COMPENSATION IS DUE FOR TEMPORARY TOTAL DISABILITY, THE ARBITRATOR FINDS AS FOLLOWS:

Based on the above, and the record taken as a whole, and in light of the Arbitrator's determination as to accident and causation (issues "C" and "F", supra), the Arbitrator finds that Petitioner failed to prove her entitlement to temporary total disability benefits pursuant to §8(b) of the Act. Accordingly, Petitioner's claim for same is hereby denied.

WITH RESPECT TO ISSUE (M), SHOULD PENALTIES BE IMPOSED UPON THE RESPONDENT, THE ARBITRATOR FINDS AS FOLLOWS:

Based on the above, and the record taken as a whole, and in light of the Arbitrator's determination as to accident and causation (issues "C" and "F", supra), the Arbitrator finds that Respondent's conduct in the defense of this claim was neither unreasonable nor vexatious so as to warrant the imposition of penalties. Accordingly, Petitioner's claim for additional compensation pursuant to §19(k) and §19(l) and attorneys' fees pursuant to §16 of the Act same is hereby denied.

WITH RESPECT TO ISSUE (N), IS THE RESPONDENT DUE ANY CREDIT, THE ARBITRATOR FINDS AS FOLLOWS:

Based on the above, and the record taken as a whole, the Arbitrator finds that Respondent is entitled to a credit in the amount of $32,563.14 for temporary total disability benefits paid and a credit of $29,172.05 for medical benefits paid on account of this injury. (RX6; Arb.Ex.#2).

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Delores Ammons-Lewis,

Petitioner,

15IWCC0044

vs.

NO: 07WC 30982

Metropolitan Water Reclamation District of Greater Chicago,

Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner and Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical expenses, perspective 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 filed May 18, 2011, 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.

15IWCC0044

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: JAN 20 2015
o011515
DLG/jrc
045

David L. Gore

Mario Basurto

Stephen Mathis

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

AMMONS-LEWIS, DELORES
Employee/Petitioner

Case# **07WC030982**

METROPOLITAN WATER RECLAMATION DISTRICT OF GREATER CHICAGO
Employer/Respondent

15IWCC0044

On 5/18/2011, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.07% 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:

AMMONS-LEWIS, DELORES
317 STONEY ISLAND
CALUMET CITY, IL 60409

1401 SCOPELITIS GARVIN LIGHT ET AL
JOHN S MAGIERA
30 W MONROE ST SUITE 600
CHICAGO, IL 60603

15IWCC0044

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)

DELORES AMMONS-LEWIS,
Employee/Petitioner

v.

METROPOLITAN WATER RECLAMATION DISTRICT OF GREATER CHICAGO,
Employer/Respondent

Case # **07** WC **30982**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Maureen H. Pulia**, Arbitrator of the Commission, in the city of **Chicago**, on **4/25/11**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **6/2/07**, 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 as it relates to her right ankle sinus tarsi syndrome *is* causally related to the accident.

In the year preceding the injury, Petitioner earned **$77,213.76**; the average weekly wage was **$1,484.88**.

On the date of accident, Petitioner was **49** years of age, ***single*** with **2** dependent children.

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

Respondent shall be given a credit of **$00.00** for TTD, **$00.00** for TPD, **$00.00** for maintenance, and **$00.00** for other benefits, for a total credit of **$00.00**.

Respondent is entitled to a credit of **$00.00** under Section 8(j) of the Act.

ORDER

- The respondent shall pay the petitioner temporary total disability benefits of **$989.92**/week for **13-4/7** weeks, from **6/3/07** through **9/5/07**, as provided in Section 8(b) of the Act, because the injuries sustained caused the disabling condition of the petitioner, the disabling condition is temporary and has not yet reached a permanent condition, pursuant to Section 19(b) of the Act.

Respondent shall pay reasonable and necessary medical services to Performance Foot and Ankle Centers, Dr. Wittmayer, Dr. Ing and Dr. Beckett as outlined in "Section J. Medical Expenses" Section of this decision, 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 by respondent's group carrier, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

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

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

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

Signature of Arbitrator

5/18/11
Date

ICArbDec19(b)

MAY 18 2011

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

Petitioner sustained an accidental injury that arose out of and in the course of her employment by respondent on 6/2/07 when she tripped over an uneven piece of concrete covered with metal while entering through doors leading to the Concentration Tanks. Petitioner testified that after showing a fellow laborer where some bugs were coming from she was walking down the road of Concentration Tanks. As she entered through the overhead doors she tripped over an uneven level of concrete covered with a metal piece. Petitioner tried to keep from falling but was unable to and hit the concrete pavement. Petitioner testified that as she fell her shoes and helmet fell off and her clipboard went flying. She testified that she landed face down on the concrete pavement. Petitioner reported twisting her right ankle and hitting her right shoulder and entire front part of her body on the floor.

After falling, a female laborer ran to her assistance. Petitioner remained on the ground for a moment and then got up and limped to her cart. Ali, the laborer that had been accompanying petitioner, drove the cart back to the Digester Office area. Petitioner and Ali went into the kitchen area. John Scannell and other supervisors were there. Petitioner testified that she sat in a chair and raised her pant leg and noticed that her leg was swollen. Petitioner reported the accident. An accident report was completed and she was offered medical treatment.

Petitioner was taken to Roseland Community Hospital by Chicago Paramedics. Petitioner was seen in the emergency room. The Fast Track note indicates a left shin injury that was sharp and burning. The Physician Documentation noted a chief complaint of left leg pain. The history noted was that the petitioner had presented after falling at work and striking her left leg on concrete. An examination revealed ecchymosis of the left shin – medial aspect, minimal antalgia. The diagnosis was blunt trauma of the left leg. An x-ray of the left lower leg was taken and the impression was a negative left lower leg. Petitioner was prescribed ibuprofen and focal modalities. Estimated return to work was noted as 6/4/07. Petitioner was instructed to follow-up with her doctor.

After being discharged petitioner returned to work to pick up her vehicle. Someone else drove petitioner's car home for her. On Monday June 4, 2007 petitioner called respondent's Human Resources Department to inform them of her treatment. She also faxed the documents from the emergency room to respondent. Petitioner received authorization from Sandra Belford, the claims adjuster to receive follow-up treatment at Ingall's Occupational Health Program.

On 6/6/07 petitioner presented to Ingall's Occupational Health Program and was seen by Dr. Akhtar. Petitioner gave a history of falling and injuring her left leg, right ankle, right shoulder and upper

chest. She stated that she "tripped on uneven surface with left foot then fell forward onto the cement. Shoes fell off during fall. C/o pain [in] R ankle, L lower leg, bilateral wrist, R shoulder, upper chest. Denies sternal chest pain, denies dyspnea, did not hit head, no loss of consciousness." Petitioner noted that it is worse when she is walking or standing, and climbing stairs. She reported throbbing and burning. The mechanism of injury in Dr. Akhtar's report was noted as "the patient states that she tripped on cement ledge and fell forward, struck her left shin, twisted her right ankle and her right shoulder." A mild antalgic gait was noted. An inspection of the right shoulder revealed no external evidence of an injury. On palpation she had tender points mostly over the anterior shoulder and outer pecoralis. Mild posterior axillary notch tender points were noted. Petitioner demonstrated full range of motion with only mild discomfort. All provocative tests caused a mild degree of discomfort. Neurovascular was intact to all extremities. Inspection of the right ankle revealed some faint ecchymosis inferior to the anterior tibial plateau. Mild tender points were noted over the medial aspect of the knee. Petitioner's right ankle sprain was noted as a grade 2. Petitioner was able to squat only about 30-40 degrees due to pain in the right ankle. The petitioner was noted as being obese. Dr. Akhtar's assessment was "status post fall with right ankle sprain, left lower leg contusion and knee sprain, and right shoulder sprain." Petitioner was given an ankle air cast. She was instructed to follow-up in a week. She was released to restricted duty work. She was restricted to occasional standing/walking, no overhead work with right arm over 20 minutes an hour, a sitting job, and no climbing ladders. Dr. Akhtar was of the opinion that if there was no improvement upon follow-up then therapy would be considered. Dr. Akhtar did not suspect any internal derangement of any of the joints injured. Petitioner was discharged in good condition. Petitioner sent her light duty restrictions to respondent's Human Resources Department and to Paul Wysocki, the plant supervisor. Petitioner testified that she was informed by respondent that she could not return to work since respondent had no light duty work available.

On 6/8/07 petitioner applied for duty disability. That same day petitioner presented to Dr. Vincent Ing, a chiropractor. Dr. Ing performed a neurological examination. He authorized petitioner off work. Petitioner underwent 23 treatments with Dr. Ing between 6/11/07 and 7/24/07. On 6/26/07 she reported that her back was killing her and had not previously mentioned it because she felt it was just "everyday" soreness, but was getting worse.

On 7/16/07 respondent drafted a letter to petitioner stating that they had investigated her claim for worker's compensation benefits, and did not find her claim to be compensable under the Illinois Workers'

Compensation Act. They further informed her that her claim was being denied. Petitioner was asked to advise her supervisor of her work status.

Petitioner requested a leave of absence from 7/20/07 through 8/6/07 because she had not yet been released by the doctor and had 2-3 more weeks of therapy due to her injury at work. Dr. Ing noted on the request that he had not yet performed a final evaluation of petitioner since he was waiting for the results of her MRI.

On 7/23/07 petitioner underwent an MRI of the right ankle with contrast. The MRI revealed evidence of edema noted along the circumference of the right ankle; findings consistent with a sinus tarsi syndrome of the right ankle; and mild tenosynovitis of the posterior tibial tendon of the right ankle.

On 7/25/07 Dr. Ing drafted a letter to respondent stating that petitioner was suffering from lumbosacral radiculitis and injury to the right ankle. He noted that she had been hurt at work. He was of the opinion that petitioner was unable to return to work due an inability to perform the essential functions of her job. He indicated that petitioner's condition was temporary, however she would need time to recover. He stated that petitioner was undergoing treatment and he anticipated that she would return to work in approximately 3-6 weeks.

Between 7/27/07 and 8/30/07 petitioner underwent an additional 18 treatments with Dr. Ing for the injuries she sustained on 6/2/07. Petitioner continued to complain of swelling and pain. On 8/10/07 Dr. Ing noted that petitioner was walking better. On 8/13/07 it was noted that her ankle was no longer as swollen. On 8/15/07 it was noted that petitioner "must have bumped it," and that her ankle was tender and sore. On 8/24/07 it was noted that petitioner was "getting better". Edema was noted in the ankle. On 8/27/07 petitioner stated that her ankle continued to hurt. Her edema was noted as being less severe. On 8/29/07 it was noted that petitioner no longer needed her ankle support. Petitioner complained of walking with a limp. Her swelling was noted as being "diminished somewhat".

On 9/4/07 petitioner last presented to Dr. Ing. His notes indicate "improving with care – returned to work". Petitioner's daily progress note for 9/4/07 indicated a pain level of 2 on a scale of 10 and subjective ankle/foot pain. Petitioner noted no shoulder or low back pain. Dr. Ing drafted a letter to "Sir or Madame" releasing petitioner to work as of 9/5/07.

After being released to return to work by Dr. Ing, petitioner also had to be cleared to return to work by respondent's doctors at Concentra. Petitioner was examined at Concentra on 9/5/07 and released to return to regular duty work.

On 9/5/07 petitioner returned to her regular duty job as a Stationary Operating Engineer I. This was the same job petitioner was working on 6/2/07. Despite her release from care and release to full duty work petitioner reported that she was still experiencing pain in her right ankle. She further stated that she could not stand for long periods of time. Petitioner testified that she had no choice but to return to work claiming her medical and dental benefits had been cut off. Petitioner testified that she had requested additional medical treatment be authorized by respondent, but this request was denied.

Petitioner testified that between 9/4/07 through 3/16/09 she worked her regular duty job and had no treatment. Petitioner next sought treatment from Dr. Wittmayer. Petitioner presented to Dr. Wittmayer on 3/16/09. Dr. Wittmayer was a doctor of petitioner's own choosing. She testified that she selected him because he specialized in ankle/foot injuries and the fact that she was informed that a chiropractor was not an acceptable treater.

Petitioner completed a Comprehensive Patient History form for Dr. Wittmayer. Petitioner stated that the reason for her visit was foot pain, right ankle swelling and pain. The location was identified as "both big toes." She stated that she has had this condition for "more than a month". She also stated that "it hurts when touched or rubbed by shoes". Dr. Wittmayer examined petitioner. He noted that petitioner was a new patient that came in with multiple complaints. Petitioner noted painful great toenails on both feet that had been bothering her for some time. He noted that petitioner had seen a dermatologist who performed a nail culture and stated that there was no fungus. Her secondary complaint was pain in her right ankle. She stated that about 2 years ago she had an ankle sprain and has had some continued pain and swelling in the area ever since. An examination revealed some mild edema over the anterior lateral aspect of the right ankle and sinus tarsi region. The nails were noted as being thick and mycotic appearing bilaterally. She also had some focal hyperkeratosis at the distal aspect of the hallux bilaterally. There was focal pain on palpation noted in the sinus tarsi region as well as over the anterior talo fibular ligament. Dr. Wittmayer reviewed the MRI report from 2007. Dr. Wittmayer's assessment was painful onychomycosis and sinus tarsi syndrome. He was of the opinion that most of petitioner's discomfort for her nail was coming from the hyperkeratosis at the end of the toes. He gave her a prescription for Kerol cream. For her sinus tarsi syndrome he placed her on a Medrol dose pack as well as dispensed a pair of Super Feet inserts. He offered her an injection, however, she deferred. She was instructed to follow-up in 3-4 weeks.

Petitioner next followed-up with Dr. Wittmayer on 10/19/09. Dr. Wittmayer noted that petitioner had not followed-up as recommended. Petitioner stated that she never had the Medrol dose pack

prescription filled. She complained of pain on the outside of her right ankle. She stated that "this is currently a workman's complaint". She reported pain with prolonged standing or walking on the front and outside of her right ankle. An examination revealed no significant edema. Focal pain in the sinus tarsi region as well as some mild pain across the anterior aspect of the right ankle joint was noted. Dr. Wittmayer assessed sinus tarsi syndrome status post right ankle sprain. He once again prescribed the Medrol does pack and prescribed a course of physical therapy. He instructed petitioner to follow up in 3-4 weeks.

Petitioner underwent a course of physical therapy at PTSIR through 12/18/09. Petitioner testified that physical therapy was terminated because PTSIR had received no payment from the respondent.

On 11/30/09 petitioner returned to Dr. Wittmayer for followup of her sinus tarsi syndrome. He noted that petitioner got significant improvement from physical therapy. She reported that at her worse her pain was a 5 on a scale of 10, and at times went down to between 0-2 on a scale of 10. She reported a lot more walking over the past few days due to a family member being in the hospital. She indicated that this increased walking had irritated her to some degree. An examination revealed no significant edema, some mild pain with deep palpation on the sinus tarsi region on the right foot. Dr. Wittmayer's assessment was sinus tarsi syndrome. He recommended that petitioner finish her course of physical therapy. He also discussed custom foot orthosis with her, and a cortical steroid injection which petitioner once again deferred. Dr. Wittmayer told petitioner to follow up in 4-6 weeks if she did not have any significant improvement.

On 12/2/09 Dr. Wittmayer drafted a letter to Michael Greco, petitioner's former attorney. Dr. Wittmayer noted a summary of his treatment of petitioner. Dr. Wittmayer noted that as of the last time he saw petitioner on 11/30/09 he offered her a cortical steroid injection for the third time but that she deferred. Dr. Wittmayer was of the opinion that as of 11/30/09 petitioner was making improvement in physical therapy. As far as further treatment was concerned, he was of the opinion that if petitioner continued to have pain, he would again recommend a cortical steroid injection as well as potential bracing or custom foot orthosis. Dr. Wittmayer did not expect petitioner's condition to be a permanent disability for her. With regards to his diagnosis of sinus tarsi syndrome, Dr. Wittmayer was of the opinion that since 2 years had passed before his initial evaluation of petitioner, he could not definitively say that the injury in 2007 is what caused her subjective complaints in March of 2009. Dr. Wittmayer was of the opinion that a significant ankle sprain could be contributory to petitioner's sinus tarsi syndrome. He was further of the opinion that the sinus tarsi syndrome he was treating petitioner for is

essentially an inflammatory condition in which he expected her to make a full recovery. Dr. Wittmayer was of the opinion that there has been some delay in petitioner's improvement given the fact that when he saw petitioner in March 2009 he instructed petitioner to take the Medrol dose pack and return for follow-up in 3-4 weeks, she did neither, thus causing a delay in her treatment. With respect to continued care, Dr. Wittmayer was of the opinion that petitioner was finishing up her current course of physical therapy. He indicated that if petitioner was still having symptoms thereafter, he would once again consider a cortical steroid injection, which she had been opposed to in the past. He also recommended custom foot orthosis.

On 12/8/09 petitioner had a phone conversation with Dr. Wittmayer. Dr. Wittmayer drafted a memo following this conversation. Dr. Wittmayer noted that he saw petitioner on 11/30/09 and had been following her for sinus tarsi syndrome. He noted that there were issues regarding her follow-up and follow through on ordered treatments. He indicated that petitioner had called that day with respect to the letter he sent her attorney on 12/2/09, and was of the opinion that the letter he dictated was inaccurate. He noted that petitioner was upset that he had indicated that the injury was in July 2007 when it was actually in June 2007. Dr. Wittmayer indicated that he would make this change. It was also noted that she was upset that Dr. Wittmayer said she opposed treatment. Dr. Wittmayer indicated that he noted that she had deferred treatment of a subtalar joint injection. Dr. Wittmayer questioned why it took her six months after her 10/19/09 visit to return if she was still having discomfort. Dr. Wittmayer noted that petitioner could not formulate an answer and was getting argumentative and combative on the phone. Dr. Wittmayer discussed his treatment of petitioner. He also questioned her treatment with Dr. Ing, since he is a chiropractor. He questioned petitioner regarding Dr. Ing's expertise in foot and ankle treatments and why she initially saw him after the claim. Petitioner stated that after her treatment at Ingall's she felt she could be better served by a chiropractor. Petitioner stated that she went to Dr. Wittmayer for treatment because she was getting no relief. She continued to talk about pain and swelling in her ankle sprain. Dr. Ing noted that he had received no treatment records from Dr. Ing and the records of Ingall's urgent care and that if she wanted any other changes in the note she would need to get him the records of Dr. Ing and Ingall's urgent care and he would assess the care she received. Petitioner stated that on her initial visit she clearly stated that this was a workman's comp claim and had provided a compensation number at that time. Dr. Wittmayer noted that to his account the visit had been billed to her private insurance due to her not having a claim number at the time of the initial visit. Dr. Wittmayer indicated that he would be more than happy to redo the letter after she gathered the requested information and sent it to him for review.

On 12/17/09, James LoPiccolo, physical therapist at PTSIR, noted that petitioner had completed 15 physical therapy sessions and was reporting an aching sensation in the lateral ankle mainly with prolonged standing. He noted that a new referral would be required to continue with the petitioner's care beyond that week. It was noted that petitioner was less tender to palpation over the lateral malleolus and over the dorsal aspect of the foot; her pain rating at worst was 4/10; her gait pattern was unremarkable; and, her LEFS score increased from 30/80 to 54/80, which represented functional improvement. The petitioner was instructed in a detailed home exercise program. Treatment had consisted of ice, electric stimulation, manual therapy and therapeutic exercise with a home program.

On 12/22/09 petitioner followed-up with Dr. Wittmayer for her sinus tarsi syndrome. He noted that she had been undergoing physical therapy with some improvement. After being on her feet for prolonged periods she still reported an aching dull pain in the region of the sinus tarsi. Otherwise, Dr. Wittmayer noted that petitioner was doing well. Petitioner also question Dr. Wittmayer regarding her unrelated nail culture. On examination Dr. Wittmayer noted no significant edema. However, petitioner complained of some pain with deep palpation of the sinus tarsi region. Dr. Wittmayer noted that her toenails were thick and mycotic appearing. Dr. Wittmayer's assessment was sinus tarsi syndrome and onychomycosis. Petitioner again offered petitioner an injection which she deferred. She stated that she wanted to continue with physical therapy. Dr. Wittmayer ordered another 2 weeks of physical therapy. If she had no improvement after that, Dr. Wittmayer recommended an injection. Dr. Wittmayer also made some recommendations with respect to her unrelated toenail fungus. Dr. Wittmayer told petitioner that he did review the records of Dr. Ing and Ingall's Occupational Health and revised his letter to her attorney. He explained to petitioner that given some lapse from the initial injury to his initial assessment, he could not fully say that her sinus tarsi syndrome is due to her ankle sprain. He further told her that it is plausible given the fact that sinus tarsi syndrome often follows ankle sprain injuries. Dr. Wittmayer told petitioner to follow-up in 2 weeks.

On 1/5/10 petitioner returned to Dr. Wittmayer for follow-up of her sinus tarsi syndrome. Petitioner reported that she missed some therapy due to her fiancé being ill and she had to fly to Connecticut to get him. She was going to restart therapy that week. Dr. Wittmayer noted that overall petitioner's symptoms were improving but she still had pain over the sinus tarsi region. An examination revealed minimal edema, focal pain on palpation of the sinus tarsi region of the right foot, and no gross instability. Dr. Wittmayer's assessment remained the same. Dr. Wittmayer noted that petitioner had been bothered by this problem for some time. He again discussed injections with petitioner and she stated that

she would like to proceed. Dr. Wittmayer performed an injection to the point of maximum tenderness to the right sinus tarsi. Dr. Wittmayer also addressed her positive fungus culture and recommended treatment for her toenails.

On 1/25/10 petitioner followed-up with Dr. Wittmayer for her sinus tarsi syndrome as well as her onychomycosis. Petitioner reported that her symptoms following her right sinus tarsi injection had greatly improved. Petitioner discussed complaints regarding her unrelated onychomycosis with Dr. Wittmayer. An examination revealed no significant edema on the right foot and no pain on palpation over the sinus tarsi. Dr. Wittmayer recommended that for her sinus tarsi syndrome petitioner continue her current treatment plan. He noted that she has a home program from physical therapy. He also continued her treatment for her unrelated onychomycosis. Dr. Wittmayer instructed petitioner to follow up as needed.

On 9/27/10 petitioner returned to Dr. Wittmayer with a chief complaint of pain on the back of her right heel. She reported that about three weeks ago she was bringing her foot down and hit it on the back of a metal chair, and has continued with pain since that time. Petitioner testified that this incident occurred at home. On examination Dr. Wittmayer noted no breaks in the skin or discoloration; some mild edema at the insertion of the Achilles tendon on the right foot; pain on palpation in this region; strength of 5/5; intact Achilles tendon; and, no hypertrophy or irregularities. An x-ray revealed no fractures or discolorations and a small retrocalcaneal exostosis. Dr. Wittmayer assessed insertional Achilles tendonitis of the right foot and exostosis. Dr. Wittmayer dispensed a heel lift and placed her on Naprosyn 5000 mgs twice a day. He instructed her to follow-up in 3-4 weeks for reevaluation. There were no documented complaints regarding petitioner's sinus tarsi syndrome.

Petitioner testified that she returned to Dr. Wittmayer on 3/14/11. Petitioner testified that she was referred for physical therapy at Flexion. As of trial, petitioner had not yet received a copy of Dr. Wittmayer's records regarding this visit.

Petitioner offered into evidence photos of the accident scene and a photo of her left thigh taken 6/2/07 and photos of her right ankle taken 6/6/07.

Petitioner testified that she is still working for respondent in the same job she was working on 6/2/07. Petitioner testified that she has received increases in her wages since 6/2/07.

Petitioner offered into evidence the following out-of-pocket expenses:

- 9/27/10 - Performance Foot and Ankle Centers (Dr. Wittmayer) – adjustable heel lift - $12.00
- 3/16/09 - Performance Foot and Ankle Centers (Dr. Wittmayer) – Arch supports-Supper Feet- $35.00
- Dr. Wittmayer – total co-pays $266.30
- Dr. Ing - $200.00 (2/10/08 and 10/4/07)
- Dr. Beckett - $34.00 (for x-rays in Roseland emergency room.

F. IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY?

It is unrebutted that petitioner sustained an accidental injury that arose out of and in the course of her employment by respondent on 6/2/07. Petitioner tripped over an uneven piece of concrete covered with metal while entering the doorway to the concentration tanks. Petitioner testified that she fell forward landing on the concrete pavement. She reported twisting her right ankle and hitting her right shoulder and entire front part of her body on the floor.

Petitioner was first seen at Roseland Community Hospital emergency room that same day. The records only indicate an injury to the left leg. An examination revealed ecchymosis of the left shin – medial aspect, minimal antalgic. Petitioner was diagnosed with blunt trauma of the left leg.

Petitioner next treated on 6/6/07 with Dr. Akhtar at Ingall's Occupational Health Program. Petitioner reported falling and injuring her left leg, right ankle, right shoulder and upper chest. She complained of pain in her right ankle, left lower leg, bilateral wrist, right shoulder and upper chest. An inspection of the right shoulder revealed no external evidence of an injury. On palpation she had tender points mostly over the anterior shoulder and outer pecoralis. Mild posterior axillary notch tender points were noted. Petitioner demonstrated full range of motion with only mild discomfort. All provocative tests caused a mild degree of discomfort. Neurovascular was intact to all extremities. Inspection of the right ankle revealed some faint ecchymosis inferior to the anterior tibial plateau. Mild tender points were noted over the medial aspect of the knee. Petitioner's right ankle sprain was noted as a grade 2. Petitioner was able to squat only about 30-40 degrees due to pain in the right ankle. The petitioner was noted as being obese. Dr. Akhtar's assessment was "status post fall with right ankle sprain, left lower leg contusion and knee sprain, and right shoulder sprain." Petitioner was given an ankle air cast. She was instructed to follow-up in a week. Dr. Akhtar was of the opinion that if there was no improvement upon follow-up then therapy would be considered. Dr. Akhtar did not suspect any internal derangement of any of the joints injured. Petitioner was discharged in good condition.

Petitioner next treated with Dr. Ing. Petitioner underwent over 40 chiropractic treatments through 9/4/07. This treatment included treatment for the back. On 7/16/07 respondent informed petitioner that her claim for workers' compensation benefits had been denied.

An MRI of the right ankle performed on 7/23/07 revealed evidence of edema noted along the circumference of the right ankle; findings consistent with a sinus tarsi syndrome of the right ankle; and mild tenosynovitis of the posterior tibial tendon of the right ankle.

On 9/4/07, when Dr. Ing released petitioner from his care, he noted that petitioner was "improving with care-returned to work". Dr. Ing noted that petitioner 's pain level was a 2 on a scale of 10 and she had subjective ankle/foot pain. Dr. Ing's daily progress note did not include any right shoulder or low back pain.

On 9/5/07 petitioner returned to her regular duty job. She worked in this capacity through 3/16/09. Petitioner complained of ongoing pain in her right ankle. She stated that she had difficulty standing for long periods of time. Petitioner testified that she had no choice but to return to work claiming her medical and dental benefits had been cut off.

Petitioner next sought treatment on 3/16/09. On that day petitioner presented to Dr. Wittmayer. Dr. Wittmayer treated petitioner for her sinus tarsi syndrome, as well as an unrelated painful onychomycosis. Petitioner stated that about 2 years ago she had an ankle sprain and has had some continued pain and swelling in the area ever since. An examination revealed some mild edema over the anterior lateral aspect of the right ankle and sinus tarsi region. There was focal pain on palpation noted in the sinus tarsi region as well as over the anterior talo fibular ligament. Dr. Wittmayer reviewed the MRI report from 2007. Dr. Wittmayer's assessment was painful onychomycosis and sinus tarsi syndrome. For her sinus tarsi syndrome Dr. Wittmayer placed petitioner her on a Medrol dose pack and dispensed a pair of Super Feet inserts. He offered her an injection which she deferred. She was instructed to follow-up in 3-4 weeks.

Petitioner did not follow-up again with Dr. Wittmayer until 10/19/09, about 7 months later. Dr. Wittmayer noted that petitioner had not followed-up as recommended. Petitioner stated that she never had the Medrol dose pack prescription filled. She complained of pain on the outside of her right ankle and reported pain with prolonged standing or walking on the front and outside of her right ankle. An examination revealed no significant edema. Focal pain in the sinus tarsi region as well as some mild pain across the anterior aspect of the right ankle joint was noted. Dr. Wittmayer assessed sinus tarsi syndrome

status post right ankle sprain. He once again prescribed the Medrol dose pack and prescribed a course of physical therapy. He instructed petitioner to follow up in 3-4 weeks.

Petitioner underwent a course of physical therapy at PTSIR 12/18/09. Petitioner testified that physical therapy was terminated because PTSIR had not received any payment from the respondent.

On 11/30/09 petitioner returned to Dr. Wittmayer for follow-up of her sinus tarsi syndrome. He noted that petitioner got significant improvement from physical therapy. Petitioner reported that at her worse her pain is 5 on a scale of 10, and at times goes down to between 0-2 on a scale of 10. She reported a lot more walking over the past few days due to a family member being in the hospital. She indicated that this increased walking had irritated her to some degree. An examination revealed no significant edema. Some mild pain with deep palpation on the sinus tarsi region on the right foot was noted. Dr. Wittmayer's assessment was sinus tarsi syndrome. He recommended she finish her course of physical therapy. He discussed custom foot orthosis with her. He also discussed a cortical steroid injection which petitioner once again deferred. Dr. Wittmayer told petitioner to follow up in 4-6 weeks if she had not had any significant improvement.

On 12/2/09 Dr. Wittmayer was of the opinion that as of 11/30/09 petitioner was making improvement in physical therapy. As far as further treatment was concerned, he was of the opinion that if petitioner continued to have pain, he would again recommend a cortical steroid injection as well as potential bracing or custom foot orthosis. Dr. Wittmayer did not expect petitioner's condition to be a permanent disability for her. With regards to his diagnosis of sinus tarsi syndrome, Dr. Wittmayer was of the opinion that since 2 years had passed before his initial evaluation of petitioner, he could not definitively say that the injury in 2007 is what caused her subjective complaints in March of 2009. However, Dr. Wittmayer was of the opinion that a significant ankle sprain could be contributory to petitioner's sinus tarsi syndrome. He was further of the opinion that the sinus tarsi syndrome he was treating petitioner for is essentially an inflammatory condition in which he expected her to make a full recovery. Dr. Wittmayer was of the opinion that there has been some delay in petitioner's improvement given the fact that when he saw petitioner in March 2009 he instructed petitioner to take the Medrol dose pack and return for follow-up in 3-4 weeks, she did neither, thus causing a delay in her treatment. With respect to continued care, Dr. Wittmayer was of the opinion that petitioner was finishing up her current course of physical therapy. He indicated that if petitioner was still having symptoms thereafter, he would once again consider a cortical steroid injection, which she had been opposed to in the past. He also recommended custom foot orthosis.

By 12/17/09, James LoPiccolo, physical therapist at PTSIR, noted that petitioner had completed 15 physical therapy sessions and was reporting an aching sensation in the lateral ankle mainly with prolonged standing. He noted that petitioner was less tender to palpation over the lateral malleolus and over the dorsal aspect of the foot; her pain rating at worst was 4/10; her gait pattern was unremarkable; and her LEFS score increased from 30/80 to 54/80, which represented functional improvement. The petitioner was instructed in a detailed home exercise program. Treatment had consisted of ice, electric stimulation, manual therapy and therapeutic exercise with a home program.

On 12/22/09 petitioner followed-up with Dr. Wittmayer for her sinus tarsi syndrome. He noted that she had been undergoing physical therapy with some improvement. After being on her feet for prolonged periods she still reported an aching dull pain in the region of the sinus tarsi. Otherwise, Dr. Wittmayer noted that petitioner was doing well. On examination Dr. Wittmayer noted no significant edema. However, petitioner complained of some pain with deep palpation of the sinus tarsi region. Dr. Wittmayer's assessment was sinus tarsi syndrome and onychomycosis. Petitioner again offered petitioner an injection which she deferred. She stated that she wanted to continue with physical therapy. Dr. Wittmayer ordered another 2 weeks of physical therapy. Dr. Wittmayer explained to petitioner that given some lapse from the initial injury to his initial assessment, he could not fully say that her sinus tarsi syndrome is due to her ankle sprain. However, he was also of the opinion that a causal connection was plausible given that sinus tarsi syndrome often follows ankle sprain injuries.

On 1/5/10 petitioner returned to Dr. Wittmayer for follow-up of her sinus tarsi syndrome. Petitioner reported that she missed some therapy sessions due to personal reasons. Dr. Wittmayer noted that overall petitioner's symptoms were improving but she still had pain over the sinus tarsi region. An examination revealed minimal edema, focal pain on palpation of the sinus tarsi region of the right foot, and no gross instability. Dr. Wittmayer's assessment remained the same. Dr. Wittmayer noted that petitioner had been bothered by this problem for some time. He again discussed injections with petitioner and she stated that she would like to proceed. Dr. Wittmayer performed an injection to the point of maximum tenderness to the right sinus tarsi.

On 1/25/10 petitioner followed-up with Dr. Wittmayer for her sinus tarsi syndrome as well as her onychomycosis. Petitioner reported that her symptoms following her right sinus tarsi injection had greatly improved. Petitioner discussed complaints regarding her unrelated onychomycosis with Dr. Wittmayer. An examination revealed no significant edema on the right foot and no pain on palpation over the sinus tarsi. Dr. Wittmayer recommended that for her sinus tarsi syndrome petitioner continue her

current treatment plan. He noted that she has a home program from physical therapy. He also continued her treatment for her unrelated onychomycosis. Dr. Wittmayer instructed petitioner to follow up as needed.

On 9/27/10 petitioner returned to Dr. Wittmayer with a chief complaint of pain on the back of her right heel. She reported that about three weeks ago she was bringing her foot down and hit it on the back of a metal chair, and has had continued pain since that time. Petitioner testified that this incident occurred at home. On examination Dr. Wittmayer noted no breaks in the skin or discoloration; some mild edema at the insertion of the Achilles tendon on the right foot, pain on palpation in this region, strength of 5/5, intact Achilles tendon, and no hypertrophy or irregularities. An x-ray revealed no fractures or discolorations and a small retrocalcaneal exostosis. Dr. Wittmayer assessed insertional Achilles tendonitis of the right foot and exostosis. Dr. Wittmayer dispensed a heel lift and placed her on Naprosyn 5000 mgs twice a day. He instructed her to follow-up in 3-4 weeks for reevaluation. There were no documented complaints regarding petitioner's sinus tarsi syndrome.

Petitioner testified that she returned to Dr. Wittmayer on 3/14/11. She further testified that she was referred for physical therapy at Flexion. As of trial, petitioner had not yet received a copy of Dr. Wittmayer's records regarding this visit.

Based on the above, as well as the credible record, the arbitrator finds that as a result of the injury at work on 6/2/07 petitioner sustained injuries to her left shin, right shoulder, low back and right ankle. Petitioner denied any problems with her right ankle prior to her injury on 6/2/07. The arbitrator finds that as of 9/4/07 petitioner had no further complaints regarding her left shin, right shoulder and low back. After that date, petitioner's complaints were primarily related to her right ankle. Petitioner also treated with Dr. Wittmayer for unrelated conditions of onychomycosis and insertional Achilles tendonitis of the right foot and exostosis.

After returning to her regular duty job on 9/5/07 petitioner continued to complain of right ankle pain but did not seek any additional treatment until 3/16/09. Petitioner testified that she did not seek any treatment because she could not get authorization from respondent for treatment based on the fact that her workers' compensation claim had been denied.

When petitioner presented to Dr. Wittmayer she complained of right ankle pain and swelling, as well as her unrelated onychomycosis. Petitioner reported that the pain and swelling in her right ankle had been ongoing since the injury on 6/2/07. Dr. Wittmayer wanted to inject petitioner's sinus tarsi, but she

did not want the injection at that time. He gave her a prescription for a Medrol dose pack, and told her to follow-up in 3-4 weeks.

Petitioner did not return for about 7 months. Petitioner resumed treatment with Dr. Wittmayer on 10/19/09. Petitioner treated with Dr. Wittmayer for her right ankle on 11/30/09, 12/22/09, 1/5/10 and 1/25/10. Petitioner had repeatedly deferred the recommended injection and continued with complaints of sinus tarsi syndrome. On 1/5/10 petitioner underwent the recommended injection. On 1/25/10 petitioner returned to Dr. Wittmayer and reported that her symptoms following her right sinus tarsi injection had greatly improved. An examination revealed no significant edema on the right foot and no pain on plapation over the sinus tarsi. For this condition Dr. Wittmayer recommended that she continue her current treatment plan which included a home physical therapy program. He also released petitioner on an as needed basis.

The only other documented treatment from Dr. Wittmayer through 3/13/11 was a visit on 9/27/10. When petitioner presented to Dr. Wittmayer on 9/27/10 her chief complaint was for an unrelated insertional Achilles tendonitis of the right foot and exostosis. No complaints regarding petitioner's sinus tarsi syndrome and her right ankle were noted. All treatment that day was related to her Achilles tendonitis and exostosis.

Petitioner testified that she followed-up with Dr. Wittmayer on 3/14/11 for her right ankle condition. However, at the time of this 19(b) hearing on 4/25/11 the records from Dr. Wittmayer regarding this visit had not yet been obtained by petitioner.

On 12/2/09 Dr. Wittmayer commented regarding petitioner's sinus tarsi syndrome. Dr. Wittmayer was of the opinion that since 2 years had passed before his initial evaluation of petitioner, he could not definitely say that the injury in 2007 is what caused her subjective complaints in March of 2009, when he first saw petitioner. Despite this opinion, Dr. Wittmayer also opined that a significant ankle sprain could be contributory to petitioner's sinus tarsi syndrome.

Based on this opinion, as well as petitioner's ongoing subjective right ankle complaints, objective right ankle findings, and absence of any right ankle complaints prior to 6/2/09, the arbitrator finds the petitioner's sinus tarsi syndrome is causally connected to the injury petitioner sustained on 6/2/07. The arbitrator finds the injuries to petitioner's left shin, right shoulder and low back were also causally related to the accident on 6/7/07, but had resolved by 9/4/07, the date Dr. Ing released her from his care and returned her to full duty work.

J. WERE 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 adopts her findings of fact and conclusions of law contained above with respect to the issue of causal connection and incorporates them herein by this reference. The parties stipulated that all medical bills other than the petitioner's co-pays have been paid through petitioner's group insurance. The only bills at issue are the petitioner's co-pays as follows:

- 9/27/10 - Performance Foot and Ankle Centers (Dr. Wittmayer) – adjustable heel lift - $12.00
- 3/16/09 - Performance Foot and Ankle Centers (Dr. Wittmayer) – Arch supports-Supper Feet- $35.00
- Dr. Wittmayer –$266.30
- Dr. Ing - $200.00
- Dr. Beckett - $34.00 (for x-rays in Roseland emergency room.

The arbitrator finds the treatment to petitioner's left shin, right shoulder and low back through 9/4/07 was reasonable and necessary to cure or relieve petitioner from the effects of the injury she sustained on 6/2/07. The arbitrator further finds the treatment petitioner received for her right ankle and sinus tarsi syndrome through 1/25/10 was reasonable and necessary to cure or relieve petitioner from the effects of the injury she sustained on 6/2/07.

The arbitrator finds the treatment with Dr. Wittmayer on 9/27/10 was not reasonable or necessary to cure or relieve petitioner from the effects of the injury she sustained on 6/2/07 since all documented treatment for that day was with respect to her unrelated insertional Achilles tendonitis of the right foot and exostosis. The arbitrator defers any findings with respect to any medical treatment with Dr. Wittmayer on 3/14/11 until such time that the arbitrator has the opportunity to review the subpoenaed medical records for this visit.

Although Dr. Wittmayer's records indicate the petitioner made $266.30 in payments, the arbitrator finds the petitioner is not entitled to the $40.00 payment for clerical fees dated 11/16/10 and the co-pay for 9/27/10, if any, since that treatment record includes no treatment for petitioner's right ankle and sinus tarsi syndrome on that date. The record only shows treatment for petitioner's Achilles tendonitis and exostosis

Based on the above, as well as the credible medical evidence, the arbitrator finds the petitioner is entitled to the following co-pays pursuant to Sections 8(a) and 8.2 of the Act.

- Performance Foot and Ankle Centers (Dr. Wittmayer) –$47.00 (adjustable heel lift and Arch supports-Supper Feet)
- Dr. Wittmayer –($266.30- minus $40.00 clerical fee on 11/16/10 and any co-pay for 9/27/10 visit)
- Dr. Ing - $200.00
- Dr. Beckett - $34.00 (for x-rays in Roseland emergency room.

L. WHAT TEMPORARY BENEFITS ARE IN DISPUTE?

The Arbitrator adopts her findings of fact and conclusions of law contained above with respect to the issue of causal connection and incorporates them herein by this reference.

Petitioner claims she was temporarily totally disabled from 6/3/07 through 9/9/07. Following the injury on 6/2/07 petitioner was first treated at Roseland Community Hospital and instructed to follow-up with her own doctor. On 6/6/07 petitioner presented to Ingall's Occupational Health Program at the request of respondent. She was released to light duty work. Petitioner gave the restrictions to respondent and was told that no work within these restrictions was available. Respondent offered no evidence to rebut this claim.

Petitioner began treating with Dr. Ing on 6/8/07. Dr. Ing authorized petitioner off work from 6/8/07 through 9/4/07. On 9/4/07 Dr. Ing released petitioner to full duty work beginning 9/5/07. On 9/5/07 respondent had petitioner seen at Concentra for a release to duty exam. Petitioner was given authorization to return to work.

Based on the above, as well as the credible record, the arbitrator finds the petitioner was temporarily totally disabled from 6/3/07-9/5/07, a period of 13-4/7 weeks.

STATE OF ILLINOIS)
) SS.
COUNTY OF KANE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

EDDIE LESURE,

Petitioner,

15IWCC0045

vs.

NO: 10 WC 16626

WAL-MART ASSOCIATES,

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, causal connection, medical expenses, temporary total disability benefits, and prospective 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).

Based upon a review of the record as a whole, the Commission modifies the Arbitrator's Decision, finding that Petitioner's current cervical condition is not causally related to his December 26, 2009 work injury. In so finding, the Commission relies upon the credible and more persuasive opinion of Dr. Bernstein on the issue of causal connection, the numerous treating medical records which fail to support Petitioner's testimony that he sustained a cervical injury at the time of his December 26, 2009 work injury, and Dr. Lorenz's admission his casual connection opinion was rendered in part based upon Petitioner's history of injury and symptoms

and without review of Petitioner's initial treating records documenting Petitioner's complaints and symptoms contemporaneous with his work injury.

The Commission notes the Arbitrator relied heavily on Petitioner's testimony that he had immediate onset of neck pain and that he struck his head at the time of his fall. Petitioner testified that when he slipped and fell while retrieving a customer's car on December 26, 2009, he fell onto his left-side, he hit his head and left shoulder on the ground, had neck pain from the onset, had limited motion in his neck immediately following his injury, and had ongoing radiating arm numbness. (T12-14). On cross examination Petitioner again testified he hit his head and shoulder at the time of his fall, and further testified he could not recall advising Dr. Christofersen on December 29, 2009 that he did not hit his head. (T29). A review of his initial treating records fails to support his testimony.

Petitioner initially sought medical care for his December 26, 2009 work injury on December 29, 2009, at Dreyer Medical Clinic, where he was examined by Dr. Christofersen in Occupational Medicine. At the time of his initial office visit he completed a Patient Form, providing a history of slipping and falling down on his left shoulder/arm on ice. The Patient Form fails to reflect any history of a cervical injury or of Petitioner striking his head. The December 29, 2009 office visit note reflects Petitioner provided a history of getting into a customer's car, slipping on ice, falling and landing on the posterior aspect of his left shoulder, and injuring his left shoulder. Petitioner's complaints were of pain at the back of his left shoulder, and a sore bicep. The office visit note further indicates that "He did not hit his head or lose consciousness. He does admit to some temporary (10-15) [minutes] of numbness in the arm at the time of injury, but that dissipated quickly and has not returned. He denies any other pain in the arm or any current numbness. He denies injuring any other body part." Petitioner's complaints were limited to difficulty moving his left shoulder, and he reported that he otherwise was well. Petitioner's physical neck examination was noted to be negative. Specifically his neck was noted to be supple, symmetrical without fullness, and non-tender to palpation of the trapezius muscle. His Spurling test was noted to be normal, with good cervical range of motion, good strength of the neck muscles, good circulation and sensation of the upper extremities, and without midline tenderness. The remainder of Petitioner's physical examination was normal but for findings with regard to his left shoulder: limited shoulder rotation, tenderness to palpation of the top and posterior of his shoulder, some diffuse tenderness to his scapula, pain with impingement maneuver, some weakness, slightly tender to palpation of his bicep, 5/5 grip strength and intact circulation and sensation. Petitioner was diagnosed with a contusion of the left shoulder, and a sprain of the left shoulder/arm. (PX4). A review of the initial treating office visit note fails to reflect any history of cervical complaints or of Petitioner having hit his head at the time of his work related injury.

Petitioner was seen in follow-up with Dr. Christofersen at Dryer Clinic on January 05, 2010, at which time he reported, "the pain is now located only posterior to his left shoulder and is no longer at the top as well." Petitioner's neck examination was again noted as supple, symmetrical, without fullness, and he was diagnosed with a contusion of the left shoulder. The

January 05, 2010 office visit note is void of any reference to cervical symptoms or complaints. (PX4).

Petitioner began a course of physical therapy on January 8, 2010, at which time Petitioner reported he slipped and fell onto his left shoulder, and that the reason for his referral was left shoulder pain and decreased range of motion. Petitioner's treatment was directed to his left shoulder pain. Petitioner's pain complaints were limited to pain in the posterior and superior aspects of shoulder and shoulder blade. The notes fail to reflect any complaints of neck pain or of radiating arm pain. From January 12, 2010 through June 29, 2010, Petitioner was seen 21 times in physical therapy for his left shoulder symptoms. During that time, his complaints were of continued left shoulder pain, and pain with reaching out to the side and forward. (PX4).

On January 26, 2010, Petitioner was seen in follow up by Dr. Christofersen, at which time Petitioner reported his pain had moved to the lateral part of the left shoulder and down his arm to his elbow, and he denied any numbness or tingling in the left arm. Petitioner's cervical exam was noted as supple, symmetrical without fullness. The office visit note contains no mention of cervical complaints. On February 4, 2010, Petitioner reported he had pain in the upper left arm and behind the shoulder, and made a new complaint of numbness in his left 4th and 5th fingers, without mention of any numbness or tingling in his left arm or of cervical complaints. Petitioner's neck examination was noted as unchanged, and he again was diagnosed with a contusion of the left shoulder. Petitioner was referred to an orthopedic physician for evaluation of his new complaint of numbness in his fingers. On February 16, 2010, Petitioner underwent an examination by Dr. Henderson, an orthopedic physician. He was noted to have full range of motion of the cervical spine, and a negative Spurling test. Dr. Henderson diagnosed rotator cuff tendinopathy, a possible labral tear and nerve damage, but noted that Petitioner's numbness complaint was nonspecific, involving fingers two through five. Based upon Petitioner's complaint of decreased sensation in his left 2nd through 5th fingers, Dr. Henderson recommended an MR arthrogram of the shoulder. On March 02, 2010, Petitioner was seen in follow-up by Dr. Christofersen, at which time he reported continued shoulder pain, and his neck exam was noted to be supple, and symmetrical without fullness. (PX4).

Petitioner underwent an MRI of his left shoulder on March 03, 2010, significant for a partial rotator cuff tear. On March 10, 2010 Petitioner was seen in follow-up by Dr. Henderson, at which time Petitioner complained of continued shoulder pain and numbness in his fingers. Dr. Henderson diagnosed rotator cuff tedinopathy and paresthesias in the left hand, and recommended continued physical therapy and an EMG/NCV study of the left upper extremity, and an injection of the left subacromial space was performed. On April 09, 2010 Petitioner reported temporary relief following his shoulder injection, and improvement in pain and range of motion . Dr. Henderson again recommended an EMG/NCV to address Petitioner's complaint of numbness in his 4th and 5th fingers, continued physical therapy, and referred him to Dr. Szuch for an opinion on treatment for Petitioner's rotator cuff tear. Petitioner's April 26, 2010 EMG/NCV study of his left upper extremity was found to be normal. At the time of his testing he reported a

history of a left shoulder injury, and complained of numbness of the last two digits of his left hand. (PX4).

On April 28, 2010 Petitioner sought treatment with Dr. Chudik at Hinsdale Orthopedic. At that time Petitioner provided a history of falling directly on the lateral aspect of his left shoulder at work, and complained of pain in his left shoulder and in the lateral aspect of his left neck. He denied symptoms of numbness and tingling. Dr. Chudik opined his shoulder injury was related to his work injury, recommended physical therapy and requested a copy of the prior MRI of the left shoulder. (PX2).

On May 05, 2010, Petitioner was evaluated by Dr. Szuch, an orthopedic physician at Dryer Medical Clinic. At that time, Petitioner complained of diffuse pain in his left shoulder, and some numbness and tingling in the small and ring fingers with a normal EMG/NCV study. With regard to his cervical spine, Petitioner's examination indicated no specific tenderness to palpation within his cervical spine, slightly limited cervical spine ROM and apparent guarding. Dr. Szuch diagnosed left shoulder impingement and scapular dyskinesis, and recommended additional therapy, and a left subacromial corticosteroid injection was performed.

Following his office visit with Dr. Szuch on May 05, 2010, Petitioner followed up with Dr. Chudik later that same day, with a copy of his prior MRI study. Petitioner continued to complain of left shoulder pain, and reported despite an injection earlier that day in his subacromial space. Following his examination Dr. Chudik diagnosed a left frozen shoulder, recommended continued physical therapy, continued Petitioner's off work status, and recommended he undergo an glenohumeral injection should his discomfort persist. The following day, May 06, 2010, Petitioner sought treatment with Dr. Lorenz at Hinsdale Orthopedic, on referral of his lawyer. At that time Petitioner completed a Patient Assessment form, specifically complaining of neck pain from his fall on ice on January 1, 2010, noting his pain was 9 on a scale of 1 to 10, aching, deep, and radiated to the front of his face at times. He further noted he had seen no medical provider for his problem to date. Dr. Lorenz recorded a history that Petitioner was in excellent health when at work January 10 ,2010, when walking in a parking lot, he slipped on ice and fell on his back and left shoulder. Petitioner reported he could not recall if he hit his head, but was disoriented initially. Petitioner reported his treatment had focused on his shoulder and that his neck pain had not been addressed to date. Petitioner reported his pain radiated down his arm toward the hand particularly the dorsum distribution about C7. On examination, Dr. Lorenz noted a positive Spurling maneuver to the left side, little subjective decreased sensation along C6-7 dermatomre on the left. He diagnosed a frozen left shoulder, probable rotator cuff injury, and a cervical disc syndrome with radicular irritation secondary to his fall. An MRI of the cervical spine was recommended. On May 10, 2010 MRI of the cervical spine indicated C-7, mild central and mild to moderate bilat foraminal narrowing; mild spondylotic changes at remaining intervertebral disk levels without focal disk herniation or significant compromise of the thecal sac. (PX2).

Petitioner was seen in follow-up by Dr. Szuch on June 11, 2010, at which time it was noted his left shoulder range of motion had improved, that he was doing fairly well with non-operative care, that no surgery was indicated, that two additional weeks of physical was indicated, that he would be at maximum medical improvement thereafter, and that he was discharged from his her medical care. Dr. Szuch further indicated a Functional Capacity Evaluation (FCE) would be appropriate should Petitioner feel unready to return to work. (PX4).

On July 15, 2010, Petitioner underwent a FCE, at which time it was noted he was capable of working, with recommendation he alternate tasks and lifting be restricted to the light category. His diagnosis following his functional capacity evaluation was left muscle weakness, rotator cuff tear, shoulder pain, and rotator cuff syndrome. On July 21, 2010, Petitioner was seen in follow up by Dr. Szuch. At that time, based on the FCE and Petitioner's job description, the doctor opined he was capable of returning to work with no lifting greater than 10 lbs, no balancing on the left upper extremity, and no repetitive overhead activities with the left upper extremity. Dr. Szuch further recorded, "Of note, the patient tells me he is also being evaluated by another physician for his cervical spine, and I have not addressed this with him." (PX4).

Dr. Lorenz opined Petitioner's fall on his shoulder with ensuing neck pain and radiation down the upper extremity is consistent with discogenic injury that Petitioner sustained during the process of his fall. (PX1, T8). Dr. Lorenz testified that Petitioner provided a history of neck pain and arm pain immediately after his accident. He further testified he would be "much more comfortable if there were some immediate issue with regard to the arm and neck. (PX1, T21, 25). The Commission finds a review of the treating records throughout the course of Petitioner's treatment with Dryer Medical Clinic fails to support Petitioner's testimony as to ongoing complaints of neck pain, and of numbness and tingling radiating down his left arm. The Commission further finds Dr. Lorenz relied upon the erroneous history Petitioner provided, of falling on his head and having ongoing neck and radiating arm pain, in rendering his causal connection opinion with respect to Petitioner's cervical condition of ill-being. The Commission also finds significant that Dr. Lorenz's causal connection opinion with respect to Petitioner's cervical condition was rendered without review of Petitioner's initial treating records. Dr. Lorenz admitted he did not review or have the initial records following Petitioner's work injury. (PX1, T30).

The Commission finds the opinion of Dr. Bernstein most credible and persuasive on the issue of causal connection herein. Dr. Bernstein conducted a Section 12 examination of Petitioner December 11, 2011. Dr. Bernstein testified he reviewed Petitioner's initial treating records, as well as his diagnostic studies and films. He opined Petitioner's MRI of his cervical spine was age appropriate, showing minor degenerative change, minimal bulging, no disc hernation, no nerve root compression or spinal stenosis, and no spinal cord compression. He opined the study was fairly normal, with no evidence of acute injury on the study. He further opined the MRI findings were significant in that there was no evidence of a discal injury, herniation, or findings that would support a complaint of chronic neck pain. Dr. Bernstein

testified that he could not identify an injury that explained Petitioner's subjective complaints with respect to his cervical spine, that surgery was not appropriate based on Petitioner's physical exam and the records reviewed, including the MRI and discogram. (RX1, T10-14).

Dr. Bernstein testified that even if Petitioner's discogram was came out differently, based upon fact that Petitioner did not really complain of specific neck pain for many months after his accident, it was hard for him to relate any neck findings to the work-related incident. He testified Petitioner's condition in his neck required no medical treatment, and required no work restrictions based upon lack of any serious medical condition of cervical spine. Dr. Bernstein further opined Petitioner did not sustain a cervical injury on December 26, 2009 based upon the lack of neck complaints and treatment of the cervical spine following that incident, placing significance on the fact that Petitioner did not report cervical pain for a few months after the December 29, 2009 work injury. Dr. Bernstein testified that his opinion was also based on his belief that if a patient suffers an injury of substance that results in pain complaints, limitations in functional abilities, and if have opportunity to see clinicians and have opportunity to report the pain, that is a demonstration that there's a legitimate causal connection, and that if that is absent it is hard to make that connection. (RX1, T14-17).

Although the Arbitrator stated Dr. Bernstein was uncertain of a reason for Petitioner's initial arm numbness complaints for 10 to 15 minutes after his injury, the Commission notes Dr. Bernstein testified it could have been due to a brachial plexus injury. In addition, both Dr. Lorenz and Dr. Bernstein noted Petitioner's arm complaints could be related to a shoulder injury. Most importantly, Dr. Bernstein indicated he could not radiographically identify any pathology in the cervical spine that explained Petitioner's complaints of numbness.

Furthermore, although Dr. Lorenz and Dr. Chudik found a positive Spurling maneuver, referenced by the Arbitrator as supportive of a cervical source for the injury, Petitioner's Spurling maneuver was negative during his first physical examination on December 29, 2009, three days following his work injury. The Commission also notes the Arbitrator referenced the January 08, 2010 physical therapy visit, wherein tenderness to palpation at the cervical and thoracic spines were noted, however the office visit notes contain no complaint of neck pain and the notes fails to reflect the therapist conducted a cervical spine examination, a Spurling maneuver, or any neurological testing.

Based upon a review of the record as a whole, and the reasoning stated herin, the Commission finds that Petitioner failed to prove his current cervical condition is causally related to his December 26, 2009 work injury.

With regard to the issue of temporary total disability benefits, the Commission vacates the Arbitrator's award of benefits under Section 8(b) of the Act from July 22, 2010 through August 07, 2013 based upon a finding Petitioner failed to prove a causal connection between his December 26, 2009 work injury and his cervical condition, and based upon a finding that

Petitioner reached maximum medical improvement on July 21, 2010, with regard to his December 26, 2009 left shoulder injury.

On July 15, 2010 Petitioner underwent an FCE, based upon a referral made by Dr. Szuch. The physical therapist recommended Petitioner could work with job restrictions including alternating tasks and lifting in the light category, up to ten pounds frequently and occasional lifting up to 20 pounds.

On July 21, 2010, Petitioner was seen in follow-up by Dr. Szuch. During that office visit Dr. Szuch noted that Petitioner had done fairly well with non-operative treatment to his left shoulder, and that he continued to improve. During that office visit Dr. Szuch also noted that Petitioner advised that he had been released from his employment with Respondent based upon his inability to perform his job duties. Based on the July 15, 2010 FCE and Petitioner's job description, and Petitioner's claim he was terminated from his employment based upon an inability to perform all of his required job duties, Dr. Szuch released him to return to work with permanent work restrictions with regard to his left upper extremity - no lifting greater than ten pounds, no balancing on the left upper extremity, and no repetitive overhead activities with the left upper extremity. The doctor further noted Petitioner was capable of meeting the remainder of the requirements of the job demands as depicted in the dictionary of occupational titles. (PX4).

Although on July 21, 2010 Dr. Szuch recorded a history of Petitioner being terminated from his employment with Respondent based upon an inability to perform his job duties, Petitioner testified at the time of hearing that he continued working for Respondent with restrictions until the day he was terminated, April 26, 2010, and that he was terminated following an investigation of an allegation he engaged in misconduct and sexual harassment of a co-worker on March 23, 2010. (T21-26). On cross-examination, Petitioner further admitted that as of his December 26, 2009 date of accident, he had been demoted by Respondent to drive customer's cars into the auto shop, that his job duties at that time only required him to drive the customer's cars into the shop, that he was on light duty at that time for reasons unrelated to his December 26, 2010 work injury, that no doctor has restricted him from driving any vehicles to date, and that he currently drives his own personal vehicle. (T27-29). Most importantly, Petitioner admitted that the permanent work restrictions recommended by Dr. Szuch on July 21, 2010 fell within the light duty job Petitioner had been performing for Respondent as of the date of his injury. (T38-39).

Based upon the Commission's finding as to causal connection with regard to Petitioner's cervical condition as stated herein, as well as the Commission's finding Petitioner was at maximum medical improvement with regard to his left shoulder as of his July 21, 2010 release with permanent restrictions by Dr. Szuch, the Commission vacates the Arbitrator's award of temporary total disability benefits for the period of July 22, 2010 through August 7, 2013. The Commission finds any additional lost time incurred by Petitioner pertained to Petitioner unrelated cervical condition of ill-being. The Commission is cognizant of the findings and

conclusions of the Illinois Supreme Court in the matter of Interstate Scaffolding v. Illinois Workers' Compensation Commission, 236 Ill.2d 132, 923 N.E.2d 266 (2010), and is of the opinion that the reasoning of the Court does not apply to the case at bar. There, the Petitioner was still not at Maximum Medical Improvement as of the date of the 19(b) hearing. Accordingly, in Interstate, the Court found that the Petitioner was entitled to continuing TTD benefits, in spite of his termination from employment, for cause. In the case at bar, the Petitioner has reached a state of maximum medical improvement, as is evidenced by the findings, conclusions and permanent restrictions imposed by Dr. Szuch, on July 21, 2010. It is for this reason, and the others stated hereinabove, that the Commission refuses to order the payment of any additional TTD benefits.

Based upon the Commission's finding at to causal connection with regard to Petitioner's cervical condition as stated herein, the Commission vacates the Arbitrator's medical award of $7,922.00 under Sections 8(a) and 8.2.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 04, 2013, is hereby modified as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $302.67 per week for a period of 12-1/7 weeks, for the period of April 28, 2010 through July 21, 2010, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that the Arbitrator's award of temporary total disability benefits under §8(b) of the Act for the period of July 22, 2010 through August 07, 2013, is hereby vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that the Arbitrator's award of $7,922.00 for medical expenses under §8(a) and subject to §8.2 of the Act is hereby vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that the Arbitrator's award of prospective medical care under Section 8(a) of the Act, in form of a decompression and fusion at C5-C6 and C6-C7, as prescribed by Dr. Lorenz, is hereby vacated.

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $3,800.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JAN 20 2015
KWL/kmt
O-11/18/14

Kevin W. Lamborn

Michael J. Brennan

DISSENT

Respectfully, I dissent from the majority. In particular I am moved by the 14 page decision written by the Arbitrator who carefully analyzed the particular facts of this case as well as the established law in the State of Illinois. Arbitrator Dollison found the Petitioner to be credible and his case to have merit. The unmitigated gall to cut off temporary total disability benefits is beyond outrageous. The law is crystal clear, an employer's obligation to pay temporary total disability benefits to an injured employee does not cease because the employee has been discharged – whether or not the discharge was for "cause." Arbitrator Dollison got it right, that is, whether the claimant's condition has stabilized. Arbitrator Dollison correctly awarded temporary total disability benefits from April 28, 2010 through August 7, 2013. Petitioner was restricted from work during this period and Respondent offered no actual evidence as to why it withheld work and temporary total disability benefits during this period.

The Arbitrator found On December 26, 2009, while working outside as a service writer, Petitioner slipped on ice while in the process of retrieving an auto that was to be inspected inside. There was snow and ice on the ground he slipped and fell on his left side, hit his head and his left shoulder on the ground. He remained on the ground until someone from inside came out to help him. He could not use his left arm for 10 or 15 minutes as it became numb after the fall. The

accident was reported immediately. Thereafter he was transported to Dreyer Occupational Health Clinic by his employer.

Petitioner began physical therapy on January 8, 2010, at Dreyer Medical Clinic. His pain was located in the top and posterior aspect of the left shoulder. He was not able to raise his arm over his head. Petitioner was given work restrictions of lifting no more than 5 pounds with his left arm. On February 16, 2010, Petitioner saw Dr. Henderson, an orthopaedic surgeon, at the Dreyer Clinic. After examination, Dr. Henderson noted the possibility of a labral tear with some nerve damage. Dr. Henderson imposed strict work restrictions until he could discover the cause of pain.

An MRI of the left shoulder was scheduled for early March 2010. It revealed tearing of the supraspinatus tendon. The doctor reviewed his tests and diagnosed Petitioner with rotator cuff tendinopathy and paresthesias in the left hand.

As the decision reveals, Arbitrator Dollison carefully weighed his observations as well as the medical opinions of the treating doctors, along with examination results of both Dr. Chudik and Dr. Lorenz. Upon examination by both Dr. Chudik and Dr. Lorenz, the Spurling test was supportive of a cervical source for the injury. The discogram further revealed that the cervical spine was a significant source for Petitioner's ongoing disability in the arm. Petitioner testified that he had continuing neck region complaints and pain into his arm and hand after the fall. But the early treatment was exclusively directed at the arm, rather than the neck.

Based on my review of the record as a whole, and taking into consideration that Petitioner was treating at the clinic designated by the employer, and leaving aside the opinion of Section 12 examiner Dr. Bernstein, the Arbitrator unequivocally found causal connection regarding the work related injuries sustained by Petitioner. Arbitrator Dollison relied on Dr. Henderson, Dr. Christofersen, Dr. Chudik, Dr. Szuch, and Dr. Lorenz. The majority seeks to rely on a few isolated facts to negate causal connection, for example, Petitioner failed to mention striking his head in one report. The majority seems to overlook the results of the MRI, the EMG/NVC and the FCE. The majority relies solely on the opinions of one doctor, rather than the full complement of physicians from Respondent's Dreyer Occupational Clinic that was only trying to give good medical care and not purchased opinions.

Red flags and bright flares light up the sky with the reminder that we must follow the law, which Arbitrator Dollison did correctly. It is patently clear that temporary total disability benefits should not be disturbed or interrupted for this worker. Respondent has created a thinly veiled scenario that they wish to rely on "good cause." However, Interstate Scaffolding, Inc. v. Ill. Workers' Comp. Comm'n, 236 Ill. 2d 132, 337 Ill. Dec. 707, 923 N.E.2d 266, (2010), is solid law and it guides and directs our actions. It quite simply tells us that an employer's obligation to pay temporary total disability benefits to an injured employee does not cease because the employee has been discharged – whether or not the discharge was "for cause."

Arbitrator Dollison understands and totally comprehends the holding in Interstate Scaffolding, as well as the limited exceptions, none of which apply to the facts of this case. In summation, the court stated "Looking to the Act, we find that no reasonable construction of its provisions supports a finding that TTD benefits may be denied an employee who remains injured, yet has been discharged by his employer for 'volitional conduct' unrelated to his injury. A thorough examination of the Act reveals that it contains no provision for the denial, suspension, or termination of TTD benefits as a result of an employee's discharge by his employer. Nor does the Act condition TTD benefits on whether there has been 'cause' for the employee's dismissal. Such an inquiry is foreign to the Illinois workers' compensation system." Id. at 146. The Arbitrator noted in this case that he was not making a determination on the veracity of Petitioner's termination and that the Commission did not condone harassment. The termination is a pure "smoke screen," a devious attempt to circumvent the law. Respondent's presentation on the harassment issue also underscores Respondent's inability to prevail on the case on its merits.

Petitioner vehemently denied that he engaged in unwanted touching of a co-worker and Respondent brought absolutely no evidence to the contrary. Respondent did not present any charging documents, witness statements, or letters explaining why Petitioner was actually terminated other than a reference to a general company policy, which covers all manner of disparate and unrelated reasons for employment decisions. Parenthetically, Petitioner was never even furnished with an employee manual.

The impermissible avoidance of temporary total disability benefits is controlled by the holding Interstate Scaffolding and all subsequent cases, including Matuszczak v. Ill. Workers' Comp. Comm'n (Wal-Mart), 2014 IL App (2d) 130532WC, and those that follow shine a bright light on how we must treat the injured worker. We cannot end temporary total disability benefits when an employee is terminated for reasons unrelated to his work related injury. For these reasons, I dissent.

Thomas J. Tyrrell

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

15IWCC0045

LESURE, EDDIE
Employee/Petitioner

Case# **10WC016626**

WAL-MART ASSOCIATES
Employer/Respondent

On 12/4/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.10% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1869 PRESBREY & ASSOC PC
KURT A NIERMANN
821 W GALENA BLVD
AURORA, IL 60506

0560 WIEDNER & McAULIFFE LTD
NICOLE M SCHNOOR
ONE N FRANKLIN ST
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF KANE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

15IWCC0045

EDDIE LESURE
Employee/Petitioner

v.

WAL-MART ASSOCIATES
Employer/Respondent

Case # **10** WC **16626**

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 **Geneva, Illinois**, on **August 7, 2013** . After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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, **12/26/09**, 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 **$23,608.00**; the average weekly wage was **$454.00**.

On the date of accident, Petitioner was **63** years of age, ***married*** with **0** dependent children.

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $ 302.67/week for 171-1/7 weeks, commencing 4/28/10 through 8/7/13, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from 12/26/09 through 8/7/13, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall pay medical expenses provided by Hinsdale Orthopaedics Associates in the amount of $722.00 and Dr. Lipov in the amount of $7,270.00. Said medical expenses shall be paid consistent with the medical fee schedule. Respondent is further entitled to a credit for all medical expenses paid.

Respondent shall further authorize the decompression and fusion at C5-6 and C6-7, as recommended by the treating surgeon pursuant to Section 8(a) of the Act.

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

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

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

Signature of Arbitrator

12/3/13
Date

ICArbDec19(b)

DEC 4 - 2013

STATEMENT OF FACTS

Petitioner testified that he was injured on December 26, 2009 when he slipped on ice in Respondent's parking lot while walking to retrieve a car. Petitioner testified that at the time of the occurrence he had been demoted to a service writer, which required him to go outside and retrieve cars. Petitioner testified that as he was walking outside to pick up a car, he slipped on ice and his left shoulder and hit his head hit the ground. Petitioner indicated that in addition to pain, he experienced numbness in his entire left arm. He provided that the numbness alleviated after 15 minutes. Petitioner reported the accident to his supervisor and he was subsequently sent Dreyer Occupational Health Services.

Records submitted show Petitioner presented to Dreyer Occupational Health Services clinic on December 29, 2009. It was noted Petitioner reported slipping and falling while retrieving a customer's car. Petitioner explained that he landed on the back of his left shoulder. It was noted that Petitioner indicated that he did not hit his head or lose consciousness. Petitioner noted numbness in the arm following the injury but advised it resolved quickly and had not returned. An examination performed by Dr. John Christofersen revealed that his neck was non-tender to palpation and no midline tenderness. Spurling's test was negative and Petitioner had good range of motion and strength of the neck. Examination of the shoulder revealed pain with impingement movement. There was also a decreased range of motion for the shoulder. The physician diagnosed the condition as a contusion. Petitioner was prescribed Naproxen, ice and he was restricted against lifting more than 5 lbs with the left arm. (PX 4)

Petitioner returned to Dreyer Clinic on January 5, 2010. Records show he reported some improvement and denied numbness and tingling. Petitioner was instructed to continue his medication and begin physical therapy. Petitioner was still unable to fully move the arm overhead. Petitioner's work restrictions were continued of no lifting over five pounds and no overhead lifting. (PX 4)

Petitioner began physical therapy on January 8, 2010 at Dreyer Medical Clinic. The January 8, 2010 therapy notes tightness and tenderness in the cervical/thoracic muscles, as well as tenderness in the shoulder region (acromioclavicular, supraspinatus, rhomboids, upper trap, lateral humerus). The therapist noted difficulty in assessing the shoulder due to Petitioner guarding the muscles. The therapist also noted that it was difficult to isolate the pain-causing structures given the diffuseness of pain throughout the left shoulder and scapular region. (PX 4)

Petitioner returned to the Dreyer Clinic on January 12, 2010. Petitioner reported that he was no better and the examination revealed mild scapular winging. His pain was still located in the top and posterior portion of the left shoulder. He was not able to move his arm overhead. Petitioner reported the onset of left hand pain. Petitioner advised that he did not believe it to be related to the work injury. Petitioner also denied numbness and tingling. Therapy was again recommended and work restrictions were given against more than 5 lbs of lift with the left arm. (PX 4)

Therapy notes from January 22, 2010 notes that Petitioner complained that treatment was causing sharp anterior shoulder pain and pain down the side of his arm. The following therapy visits note ongoing problems with the shoulder, including fatigue, range of motion limitations and decreased strength. The therapist's diagnosis evolved from left muscle weakness/pain in limb/shoulder pain/shoulder stiffness on January 8, 2010 to left muscle weakness/rotator cuff tear/shoulder pain/rotator cuff syndrome by March 26, 2010. (PX 4)

Petitioner returned to the Dreyer Clinic on January 26, 2010. He reported no improvement and that the pain moved to the lateral part of the left shoulder and down the arm to the elbow. At that time, Petitioner denied numbness and tingling in the left upper extremity. Examination revealed mild scapular winging on the left. Based on Petitioner's failure at conservative treatment, he was referred for an orthopedic evaluation and continued his work restrictions of no lifting over five pounds and no overhead lifting with the left arm. (PX 4)

Petitioner attended a follow-up appointment at Dreyer Clinic on February 4, 2010. He reported no improvement and complained that he developed numbness in his fourth and fifth fingers of the left hand. Dr. Christofersen provided work restrictions. Petitioner was again advised to see an orthopedic physician and he was restricted to right hand work mainly and 0 lbs of lifting with the left arm. (PX 4)

On February 16, 2010, Petitioner saw Dr. Henderson, an orthopedic physician at Dreyer Clinic. Petitioner reported to Dr. Henderson that his entire arm was numb. Dr. Henderson's examination revealed slight muscle wasting inferior to the posterolateral aspect of the acromion as well as slight scapular winging. Range of motion was reduced for forward flexion, abduction, external rotation and internal rotation. Testing found positive signs for the Jobe's test, Hawkins test, Neer test, Yergason's test, Speed test and O'Brien's test. Dr. Henderson also documented numbness and decreased sensation in fingers 2 through 5. His impression was rotator cuff tendinopathy. The doctor also noted the possibility of labral tear with some nerve damage. Dr. Henderson ordered a MRI arthrogram. (PX 4)

On March 2, 2010, Petitioner followed-up at the Dreyer Occupational Health Clinic. Petitioner reported that his pain was located diffusely in the shoulder and down into the scapula. The pain was throbbing, especially by the end of the day. He was not able to fully move the arm into an overhead position and he complained of numbness in fingers 3 to 5. The doctor recommended that Petitioner engage in gentle range of motion exercises, and imposed strict work restrictions to prevent using the arm until they could figure out what was causing his pain. Petitioner was referred back to Dr. Henderson in the orthopedic department. (PX 4)

According to the records at Dreyer Clinic, the MRI arthrogram of the shoulder was carried out on March 5, 2010. It revealed tearing of the supraspinatus tendon. There were also moderate AC joint degenerative changes and a small amount of fluid in the subacromial/subdeltoid bursa and small glenohumeral joint effusion. (PX 4)

Petitioner returned to Dr. Henderson March 10, 2010. Testing found positive signs for the Jobe's test, Hawkins test, Neer test, and Speed test. Dr. Henderson also documented slight decreased sensation in all of the fingers in the left hand. The doctor reviewed the diagnostic test and diagnosed Petitioner with rotator cuff tendinopathy and paresthesias in the left hand. Dr. Henderson provided a cortisone injection into the left subacromial space and ordered an EMG/NCV. (PX 4)

Petitioner testified that he had been working light duty. He was subsequently terminated by Respondent on April 28, 2010 for what was deemed misconduct and sexual harassment. Petitioner testified that he was accused of kissing a co-worker on the cheek. Petitioner denied that a kiss happened. Petitioner explained that he and the co-worker had known each other for some time and he had been working to bring her into the church. They took smoking breaks together at work and Petitioner outlined a history of non-work interactions with this co-worker, including occasions where he helped the co-worker out with food and automotive repairs. Petitioner provided that on the day of the purported misconduct, the co-worker told Petitioner about some positive grades that her daughter had received. Petitioner stated that he congratulated her, hugged her, but denied he kissed her.

Petitioner next saw Dr. Henderson on April 9, 2010. At that time he reported temporary relief from his therapy sessions and the cortisone injection. Overall, Petitioner had improvement with therapy and the

corticosteroid injection. Examination findings continued to show positive impingement findings (Neer, Hawkins) and a positive Jobe's finding. Dr. Henderson diagnosed a rotator cuff tear and referred Petitioner for an EMG and an evaluation with Dr. Neena Szuch for the rotator cuff tear. He also recommended Petitioner continue physical therapy. (PX 4)

The EMG/NCV was performed on April 22, 2010. The results were reported as normal for the left upper extremity. (PX 4)

Therapy records reviewed show that by April 27, 2010, Petitioner was still reporting pain levels between 8 to 10 and decreases in shoulder range of motion, strength, tolerance for activities and continued pain. (PX 4)

On April 28, 2010, Petitioner began treating with Dr. Steven C. Chudik at Hinsdale Orthopaedics. Petitioner reported a history of persistent left shoulder pain after a fall on ice at work. Dr. Chudik recorded that Petitioner complained of pain in the superior lateral aspect of his left shoulder as well as the lateral aspect of his left neck. Dr. Chudik's examination revealed shoulder findings as well as left trapezius pain upon Petitioner extending and rotating his cervical spine. No numbness or tingling was noted. Dr. Chudik noted that Petitioner's left shoulder injury was caused by the fall at work. (PX 2)

On May 3, 2010, Petitioner was evaluated by Dr. Kenneth Schiffman at Hinsdale Orthopaedics. Petitioner complained of right hand pain, numbness and tingling since April 2009. Petitioner reported that he did not feel these symptoms until April 2009 but was told the symptoms were related to aging. Dr. Schiffman diagnosed probable right carpal tunnel syndrome and trigger digits of the right middle and ring fingers. At that time, Dr. Schiffman instructed Petitioner to return to regular work without restrictions. (PX 2)

Petitioner returned to Dreyer Clinic on May 5, 2010 where he was examined by Dr. Szuch, an orthopedic physician. Dr. Szuch read the arthrogram as showing interstitial tearing of the cuff, but not a complete tear. Examination findings included a limited cervical range of motion with apparent guarding. Dr. Szuch also documented scapular dyskinesis with asymmetry of the left scapula, along with mild medial winging. Neer and Hawkin's impingement tests were positive and Petitioner exhibited weakness with abduction of the arm. Dr. Szuch opined that the impingement could be related to the fall, although Dr. Szuch was more concerned with the scapular dyskinesis. Dr. Szuch recommended additional therapy and she injected cortisone into the left subacromial space. (PX 4)

Petitioner also saw on Dr. Chudik on May 5, 2010. Dr. Chudik reviewed the left shoulder MRI and noted a thickened capsule but no obvious rotator cuff tears. Dr. Chudik diagnosed left frozen shoulder and recommended physical therapy and a glenohumeral injection. He also recommended Petitioner remain off work. (PX 2)

On May 6, 2010, Petitioner first presented for evaluation with Dr. Mark Lorenz at Hinsdale Orthopaedics. Petitioner reported that on January 1, 2010 he was walking in the parking lot and slipped on ice. He reported that he fell on his back and left shoulder and could not recall if he hit his head. Petitioner complained of neck pain. The doctor noted that Petitioner had been treating conservatively and also seen by Dr. Chudik. Petitioner reported that he presented "...because of neck pain that so far ha[d] not been addressed, and he is frustrated about it." He reported the pain radiated down to the hand particularly to the dorsum distribution about C7. On examination, Petitioner had a positive Spurling maneuver to the left side and subjective decreased sensation along the C6-7 dermatome on the left. X-rays revealed mild spurring from C5 to C7 but were otherwise unremarkable. Dr. Lorenz diagnosed cervical disc syndrome with radicular irritation secondary to the fall and recommended a cervical spine MRI. Petitioner was also kept off work. (PX 2)

At Dr. Lorenz's request, Petitioner underwent a MRI of the cervical spine on May 10, 2010. It revealed C6-7 mild central and mild to moderate bilateral foraminal narrowing, and mild spondylotic changes at the remaining intervertebral disc levels without focal disc herniation or significant compromise of the thecal sac. (PX 2)

Petitioner returned to Dr. Szuch on June 11, 2010. The doctor noted that therapy had improved his scapular control and shoulder range of motion. Dr. Szuch felt that Petitioner was progressing well with non-operative treatment. She did not feel surgical intervention was appropriate at that time. Dr. Szuch recommended an additional two weeks of physical therapy followed by a home exercise program. Thereafter, she noted, Petitioner would be at maximum medical improvement. The doctor also noted that if Petitioner continued to feel unready for work, he would be a candidate for a Functional Capacity Evaluation. At that time, Dr. Szuch discharged Petitioner from the Orthopaedic Clinic. (PX 4)

On June 16, 2010, Petitioner returned to Dr. Steven Chudik. Petitioner reported left shoulder improvement but still had pain at the extreme range of motion. Dr. Chudik diagnosed a left frozen shoulder with possible rotator cuff injury. He recommended continued physical therapy followed by a home exercise program. He also kept Petitioner off work. During physical therapy for his shoulder, Petitioner continued to note stiffness in his neck. (PX 2 and 4)

Petitioner returned to see Dr. Lorenz on July 14, 2010. Dr. Lorenz noted the cervical MRI revealed degenerative changes at C5-6 and C6-7, with moderate bilateral foraminal narrowing and central spinal stenosis at C6-7. Petitioner continued to complain of pain at the base of his neck. His pain level was six (6) at best and ten (10) at worst. Dr. Lorenz recommended a discographic study and continued Petitioner off work. (PX 2)

Petitioner underwent a Functional Capacity Evaluation on July 15, 2010. The evaluator opined that Petitioner would not be able to complete his job safely. It was noted that there were too many tasks that Petitioner did not meet the job demands. It was reported that Petitioner had difficulties with overhead work, repetitive work, carrying, lifting, pushing and pulling. The evaluator noted Petitioner did not have good strength or stability in the left shoulder. The evaluator felt Petitioner could perform a job that required alternating tasks and lifting in a light category. (PX 4)

Petitioner returned to Dr. Szuch on July 21, 2010. Dr. Szuch reviewed the functional capacity evaluation results and recommended permanent restrictions of no lifting greater than 10 lbs., no balancing with the left upper extremity and no repetitive overhead activities with the left upper extremity. At that visit, Petitioner advised he was being evaluated for his cervical spine. Dr. Szuch noted she had not addressed this issue with him. (PX 4)

The telephone log for Dreyer Clinic shows Petitioner calling on July 22, 2010 complaining of throbbing left shoulder pain at night at level 8. Petitioner was asking for pain medication to deal with the pain. Petitioner was instructed to consult with his primary care physician on the medication. (PX 4)

On October 8, 2010, Dr. Lipov performed a cervical discogram due to "intractable neck pain that ha[d] not responded to conventional treatments" and disc degeneration at C5-6 and C6-7. It revealed discordant pain in the neck at C4-5 and concordant pain in the neck at C5-6 and C6-7. Radiologic interpretation of the nucleograms revealed central nuclear spread with small posterior fissure with epidural spread at C4-5, diffuse degeneration with the dye spread through the entire substance of the disc with epidural spread from C5-6, and diffuse degeneration of the dye spread through the entire substance of the disc at C6-7. (PX 3)

Petitioner returned to Dr. Lorenz on December 20, 2010 to review the discogram results. Dr. Lorenz noted disorganization at C4-5 and typical pain with a lower pressure and concordant pain at C5-6 and C6-7. He

noted both were disorganized with significant posterior epidural spread most prominent at C5-6. Based on these results and Petitioner's subjective complaints with some left arm pain, he recommended a C5-6 and C6-7 anterior cervical discectomy and fusion. Petitioner was continued off work. (PX 2)

At Respondent's request, Petitioner underwent a Section 12 examination with Dr. Avi Bernstein on December 12, 2011. Dr. Bernstein indicated that Petitioner presented with complaints of shoulder pain and persistent left sided neck pain. The doctor also provided that Petitioner informed him that he was retired. In addition to performing an examination, Dr. Bernstein reviewed discogram images, the left shoulder MRI from March 5, 2010, the EMG study from April 22, 2010 and the July 15, 2010 FCE. Dr. Bernstein reported that he did not have the MRI scan or report of the cervical spine. Nor did he have a post discographic CT scan or the results of the cervical discogram. Dr. Bernstein stated that Petitioner had a fairly benign physical exam and that he found no evidence Petitioner required surgical intervention. (RX 1, Dep 2)

Petitioner testified that he disagreed with Dr. Bernstein's assertion that he informed the doctor that he was retired. When asked during cross-examination whether he was retired, Petitioner replied, "…I wasn't retired. I was 65 years old the day that I saw him and he asked me was I going to retire…No. I'm not retired. That's why I've been working at Wal-Mart…He asked me was I eligible on that day to retire at 65 – at 62 years old."

On March 21, 2012, Dr Bernstein authored a second report at Respondent's request. Dr. Bernstein provided that he reviewed additional records which included the May 10, 2010 cervical MRI and the cervical discogram dated October 8, 2010. Dr. Bernstein opined that the cervical MRI demonstrated a normal study with no significant disc degeneration, disc bulging, nerve root compression or spinal stenosis. He noted the discogram described discordant pain at C4-5 and concordant discogenic pain at C5-6 and C7 without evidence of a control disc. Dr. Bernstein provided that he was reluctant to recommend surgical intervention despite the discogram identifying concordant pain at two levels in the cervical spine. He felt the MRI was completely benign. (RX 1, Dep 3)

On April 4, 2012, Dr. Berstein authored an addendum report opining that Petitioner did not suffer a cervical spine injury as a result of a work related incident on December 26, 2009. The doctor felt there was lack of clinical complaint in the medical records and lack of radiographic evidence of mechanical injury to the spine. The doctor further added that he did not consider Petitioner a good candidate for surgery. (RX 1, Dep 4)

Petitioner did not return to Dr. Lorenz until August 29, 2012. Petitioner reported increased pain radiating down the right upper extremity. An examination revealed a positive Spurling's maneuver on the right side, consistent with a C5-6 nerve root pattern. Dr. Lorenz renewed his recommendation for the fusion and he continued the restriction from work. He further prescribed oral steroids to see whether they could calm the radiculopathy down a bit. (PX 2)

The parties obtained the evidence depositions of both Dr. Avi Bernstein and Dr. Mark Lorenz.

Dr. Bernstein testified on October 2, 2012. Dr. Bernstein provided that he examined Petitioner on December 12, 2011. At that time, Petitioner complained of left shoulder pain and pain in his neck radiating to the left side of his head and left shoulder which he attributed to the December 26, 2009 incident. (RX 1, p. 8-9) Dr. Bernstein noted his examination of Petitioner revealed only slight decreased cervical range of motion and difficulty elevating the shoulder although a neurologic examination was normal. (RX 1, p. 9) Dr. Bernstein testified that he reviewed additional records which included a cervical MRI. He opined the cervical spine MRI revealed age appropriate minor degenerative changes with only minimal bulging and no nerve root compression, spinal cord compression or spinal stenosis. Dr. Bernstein opined the MRI was basically a normal study. He explained that there was no evidence of a disc injury to support Petitioner's subjective complaints.

(RX 1, p. 11) Further, Dr. Bernstein opined that Petitioner was not a surgical candidate given the MRI and cervical discogram findings. (RX 1, p. 12) He explained that the cervical discogram did not include a control disc and Petitioner had pain at all three levels. (RX 1, p. 13) He noted that as the MRI was normal and the discogram revealed three discs with significant pain, surgery was not indicated. (RX 1, p. 13) Dr. Bernstein opined that even if Petitioner was a surgical candidate, the cervical condition is not related to the December 26, 2009 incident. The doctor indicated that he did not identify evidence of an injury. Dr. Bernstein reasoned that Petitioner did not complain of neck pain or seek treatment for his neck following the incident despite access to clinicians. (RX 1, p. 15). He also noted that Petitioner did not have complaints resulting in limitations in functional abilities. (RX 1, p. 16). He indicated that if Petitioner underwent surgery, he would have a low likelihood of success. Additionally, Dr. Bernstein noted that given the fact Petitioner had not undergone treatment since December 2010 for his cervical spine, it could reflect that Petitioner is able to deal with his symptoms. (RX 1, p. 17) Dr. Bernstein found that Petitioner did not require any cervical spine treatment or work restrictions. (RX 1, pgs. 14-15)

On cross-examination, Dr. Bernstein testified that the cervical MRI imaging demonstrated that the C4-5 level appeared normal and that said level would have presumably been Dr. Lipov's control disc. When asked to assume that C5-6 and C6-7 did produce concordant pain when the intradiscal pressure was increased, Dr. Bernstein stated that those levels were an indication of pain generators. (RX 1, pgs. 23-24)

Dr. Bernstein testified that it did not appear Dr. Lorenz based his opinions regarding treatment on both the MRI and the discogram combined. He felt Dr. Lorenz focused on the discography. (RX 1, p. 25) Dr. Bernstein also testified that landing on his back and shoulder would be a competent mechanism for jarring the cervical spine. (RX 1, p. 25) Furthermore, Dr. Bernstein testified that the reference in the medical records that Petitioner experienced ten (10) to fifteen (15) minutes of numbness down the entire arm following the accident could be consistent with an injury at C5-6 or C6-7. (RX 1, p. 29) The doctor also opined that prior to considering surgery, Petitioner should undergo conservative treatment including conditioning, strengthening, physical therapy, anti-inflammatories, and epidural steroids. (RX 1, p. 33).

Dr. Lorenz testified by deposition in the matter. Dr. Lorenz testified that he first evaluated Petitioner on May 6, 2010 and that Petitioner sustained an injury on January 1, 2010 when he fell in a parking lot and injured his arm, fell on his head and hurt his neck. (Pet. Exhibit 1, p. 6). He noted that they initially attempted to treat the neck condition conservatively. (Pet. Exhibit 1, p. 6). Dr. Lorenz explained that he was concerned about radicular irritation caused by a discogenic abnormality due to Petitioner's neck pain with positive Spurling maneuver and pain radiating down the C6-7 dermatome into the dorsum of the hand. (Pet. Exhibit 1, p. 7). He indicated that the Spurling's maneuver detects whether an abnormality in the neck is pressing on the exiting nerve root leading to arm pain. He felt this was situation in this case. (PX1 p.10)

Dr. Lorenz related Petitioner's complaints to the December 26, 2009 accident, to a reasonable degree of orthopedic certainty. (PX1 p.7-8) Dr. Lorenz explained that the fall on the shoulder with ensuing neck pain and radiation down the upper extremity was consistent with a discogenic injury that Petitioner sustained from the fall. (PX1 p.8) Dr. Lorenz further explained that because Petitioner also had arm issues from the fall, the radiculopathy would have been initially overlooked while the upper extremity was addressed. (PX1 p.9)

Dr. Lorenz sent Petitioner for an MRI to determine the exact source of his neck complaints. Dr. Lorenz testified that the MRI demonstrated endplate narrowing and a disc bulge at C5-6, which was significant enough to flatten the ventral thecal sac. (PX1 p.11) At C6-7, Petitioner had endplate spurring, evidence of bilateral stenosis with bilateral foraminal narrowing. (PX1 p.11) Dr. Lorenz explained that the degenerative changes at C5-6 and C6-7 was aggravated by the slip and fall at work. (PX1 p.11-12) Dr. Lorenz informed Petitioner that he could either live with the pain or get a discographic study to assess the cervical levels. (PX1 p.12) He provided that the discogenic study could reproduce the pain if that was where the pain was coming from and the

radiopaque dye would outline the damage in the discs. (PX1 p.12) The doctor provided that he referred the study to Dr. Lipov "because it adds as an additional blinding. So the person who does the test does not know which disc I'm suspecting…helps to eliminate bias to some degree." (PX1 p. 12)

Dr. Lorenz testified that the discographic study revealed concordant pain at the C5-6 and C6-7 levels, with the dye showing rupturing of the annulus and leakage of dye at both levels. (PX1 p.13) The doctor provided that the discogram confirmed his diagnosis and the concordant pain findings revealed that the two discs were in fact the source of Petitioner's complaints. (PX1 p.14)

Dr. Lorenz testified that at that point, Petitioner had been conservatively treating without resolution of the complaints. Dr. Lorenz provided that he offered Petitioner the "only thing that was offerable at that point in time" which was a resection of the disc or decompression and a fusion of C5-6 and C6-7. (PX1 p.14) Dr. Lorenz causally related the need for the surgical procedure to the work accident, explaining that Petitioner had no dysfunction or pain prior to the accident and that he never fully recovered from his neck-related complaints after the accident. (PX1 p.17)

On cross-examination, Dr. Lorenz was asked about the late appearance of neck complaints in the medical records. (PX1 p.22) Dr. Lorenz explained that the earlier doctors were looking for arm problems rather than neck problems. (PX1 p.22) Because the earlier physicians were upper extremity specialists, they focused on the upper extremity, but they eventually referred Petitioner to Lorenz to evaluate the neck. (PX1 p.22-23) Dr. Lorenz explained that degenerative spines are typically not painful without a traumatic event occurring to the spine. (PX1 p.28) The doctor indicated that degenerative spines tend to progressively show spurring and arthritic types of conditions as they are subjected to ongoing microtrauma of life, but they are not necessarily painful and the patients are fully functional. However, the inflammatory changes produced in a traumatic event produce a number of genetic factors which switch on vascular ingrowth and nerve ingrowth where it does not belong. These factors are all elevated in discs which are painful and not in discs which have no pain. (PX1 p.33-34) On the late appearance of the neck and arm pain, Dr. Lorenz explained that arm pain may have been confused as a shoulder injury or Petitioner may also have suffered a shoulder injury with a nerve component in the accident. (PX1 p.35) As the shoulder is addressed, other sources of pain come to light which also need attention. (PX1 p.35, 44-45) On the issue of work capacity, Dr. Lorenz thought Petitioner would be able to perform sedentary duty with position changes. (PX1 p.38) He would need a FCE to fully identify the capacities. (PX1 p.38) As a presurgical candidate, Petitioner's work capacity would not be an issue until after surgery. (PX1 p.39)

Respondent called Ms. Carleen Sager to testify. Ms. Sager is employed as a personnel coordinator for Respondent. As part of her job duties, Ms. Sager is involved in hiring, terminations, scheduling interviews, attendance and any other human resources duties. Ms. Sager further testified she is familiar with Respondent's practices regarding accommodation of work restrictions. Regarding Petitioners' job, Ms. Sager testified that Petitioner was working light duty and Respondent was accommodating his work restrictions prior to his termination in a temporary alternate duty (TAD) position. Ms. Sager advised that if an individual receives permanent work restrictions that would preclude him or her from returning to the prior job, Respondent permits the individual to continue working in the TAD position permanently. Additionally, Ms. Sager testified that working in a TAD position does not affect an employee's wages. She also explained that Respondent is able to accommodate any work restrictions, including sedentary work restrictions.

Regarding Petitioner's permanent work restrictions received in July 2010 of no lifting greater than ten pounds, no balancing with the left upper extremity and no repetitive overhead activities, Wal-Mart would have been able to permanently accommodate these restrictions. Ms. Sager testified that there is an individual currently working at the store in a permanent TAD position and has been working in that position for three to four years.

Ms. Sager testified that Respondent has a PD-19 policy, which is statement of ethics policy covering various conduct, including harassment. Ms. Sager advised that Respondent's Exhibit 5 is a specific policy under the PD-19 policy pertaining to discrimination and harassment prevention and if an individual engaged in sexual harassment or inappropriate conduct, it would fall under this policy. Additionally, violation of this policy could lead to termination. Ms. Sager also identified Respondent's Exhibit 4 as a Statement of Ethics handbook. She provided that although the employees do not all receive the handbook, all employees receive the specific policies contained within the book during orientation. She further explained that all employees are required to attend orientation to work at Wal-Mart and that she or a co-worker conducts the new associate orientation, although Ms. Sager herself prepares all of the orientation packets, regardless of who conducts the orientation. Ms. Sager testified that the handbook lists violation of the PD-19 policy as grounds for termination.

Finally, Ms. Sager indicated that the exit interview listed violation of the PD-19 policy as the basis for Petitioner's termination. She testified that kissing a co-worker or unwarranted contact is grounds for termination as it violates the previously discussed policies and any associate would have been terminated if the investigation revealed the individual engaged in the conduct.

Ms. Sager testified that she was not involved in the investigation into Petitioner's termination, she did not have access to the investigatory file and she had no personal knowledge on the details of the allegations against Petitioner. Ms. Sager testified that "PD-19" generically refers to several company policies rather than a specific policy on harassment. Ms. Sager stated that Petitioner would not have received a copy of the Statement of Ethics handbook. She also provided that Respondent's discrimination policy is dated more than a year after Petitioner's termination. Ms. Sager did not know how RX5 differed from an earlier policy she indicated would have been in place.

Ms. Sager testified that she at some point she reviewed the accident report completed by Petitioner. When posed as to whether she noticed a reference to a reported neck injury, Ms. Sager replied, "If it was on there, I would have seen it. I cannot recall…It could have been." Ms. Sager also testified that she reviewed a recorded statement "at the time of injury." Ms. Sager provided that she could not recall whether Petitioner talked about neck complaints in the statement.

Petitioner testified that he was not aware of the PD-19 policy and he didn't recall ever receiving a Statement of Ethics.

Petitioner testified that he last saw Dr. Lorenz in May 2013 and he continued to recommend surgery. Currently, Petitioner complained that his hand continuously goes numb, he has a burning sensation in his arm and limited strength. Petitioner also noted constant shoulder and neck pain. Petitioner provided that he currently takes Hyrdocodone and prescription Ibuprofen for pain. Petitioner provided that he has been taking the medication since the inception of his shoulder condition and that currently the prescriptions are provided and filled by the V.A. Clinic.

Petitioner testified that he has health insurance and despite access to medical care, he never tried to put any of the denied cervical spine treatment through his health insurance. He explained, "…I couldn't afford to put it through my group insurance if I had to take the chance that Wal-Mart wasn't going to pay for it…My mind wasn't thinking like my insurance should cover it. I had an accident at work…I thought workman's comp should pay."

Petitioner also indicated that he had not applied for any jobs after his termination as he was taken off work.

With respect to ISSUE (C.) - Did An Accident Occur That Arose Out Of And In The Course Of Petitioner's Employment By Respondent, the Arbitrator finds as follows:

Petitioner slipped and fell on ice in Respondent's parking lot while he was retrieving a car for a customer on December 26, 2009. Petitioner fell onto his left arm and back and testified that he also hit his head during the fall. Petitioner noticed immediate inability to move the left arm and a co-worker came out to help him up off the ground. Respondent offered no evidence that the accident did not occur.

The Arbitrator finds Petitioner sustained an accident that arose out of and in the course of his employment with Respondent on December 26, 2009.

With respect to ISSUE (E .)- Was Timely Notice Of The Accident Provided To Respondent, the Arbitrator finds as follows:

Petitioner's unrebutted testimony demonstrates that he reported his fall to his supervisor Ray on the day of the fall. Thereafter Respondent directed Petitioner to Dreyer Occupational Health Services for treatment.

The Arbitrator finds that Petitioner provided timely notice of injury to Respondent.

With respect to ISSUE (F.) – Is Petitioner's Current Condition Of Ill-Being Causally Related To The Injury, the Arbitrator finds as follows:

There is no real dispute that Petitioner injured his arm in the fall at work on December 26, 2009. The dispute centers on whether there is a casual relationship between Petitioner's cervical condition of ill-being and the accident sustained.

Petitioner testified that he struck his left arm and head during the accident. Medical records support the idea that he also struck his back during the accident, but that did not appear to result in significant problems. Petitioner noticed immediate numbness throughout the left arm and that he could not move or use the arm for 10 to 15 minutes. A co-worker had to pick him up off the ground. An accident report was completed. Respondent's HR witness was equivocal when posed as to whether she noticed a reference to a reported neck injury, Ms. Sager replied, "If it was on there, I would have seen it. I cannot recall…It could have been." Ms. Sager also testified that she reviewed a recorded statement "at the time of injury." Ms. Sager provided that she could not recall whether Petitioner talked about neck complaints in the statement.

Treatment initially focused on the left shoulder and arm, with therapy, medication and eventually a steroid injection into the subacromial space. This treatment largely failed to resolve Petitioner's problems. Testing of the arm revealed no obvious sources for Petitioner's disability in the upper extremity. The March 3, 2010 arthrogram revealed a partial tear of the supraspinatus but no full thickness tear. This disruption would not explain why Petitioner could not raise his arm over his head. The arthrogram findings were not serious enough to warrant surgery. Also, the April 22, 2010 EMG/NCV found no neurological problems in the arm to explain the numbness in the arm or the hand. These findings point towards an injury in the neck as the source of ongoing complaints. The records and Petitioner's response to treatment suggest injuries to both the arm and the neck.

The course of treatment also shows that the initial physicians were not convinced that the arm was the sole source of Petitioner's injury. The initial treatment with the Dreyer Clinic focused on the arm as the source of the injury. The therapist documented the most complete evaluation of the upper body, documenting cervical

findings in her January 8, 2010 initial evaluation, and further noting that it was difficult to isolate the pain generating structures given the diffuseness of the complaints. Fatigue and range of motion limitations were consistently documented for the arm, scapular winging was reported shortly after the accident and the occupational medicine doctors eventually included a diagnosis of scapular dyskinesis. On March 2, 2010, the occupational clinic doctor noted that they were still trying to figure out what was causing the pain. The orthopedic follow up visit at Dreyer contains a diagnosis of rotator cuff tendinopathy and hand paresthesias. The following EMG/NCV found no source in the arm for the numbness in the hand. At this point, Petitioner's complaints had not changed significantly from their onset at the time of the accident.

Petitioner consulted with an arm specialist on his own, Dr. Steven Chudik, on April 28, 2010. Dr. Chudik recognized the shoulder injury, but also identified radiating left trapezius pain when he had Petitioner extend and rotate his neck. Recognizing a possible cervical component to the complaints, he referred Petitioner to Dr. Lorenz to evaluate the cervical spine.

Respondent challenges causation by arguing that there were no obvious signs of a cervical injury until Petitioner saw Dr. Lorenz. That contention is somewhat accurate. However, Petitioner testified that his neck was involved in the accident. Cervical region findings are documented throughout the treatment and limitations and complaints are documented which are consistent with a cervical component to the injury. It is clear that the Dreyer Clinic doctors initially focused on the arm as the source of the problem. They worked the arm up without success and explicitly noted in the records that they were not sure the arm was the only source of the problem. Dr. Lorenz explained that cases like this are difficult to diagnose given that complaints overlap when there are both cervical and arm injuries. As the shoulder component is addressed with treatment, other sources of the problem come to light which need to be addressed. That is how Petitioner came to be referred to him.

Upon examination by both Drs. Chudik and Lorenz, the Spurling maneuver was supportive of a cervical source for the injury. The discogram further revealed that the cervical spine was a significant source for Petitioner's ongoing disability in the arm. This discographic study reproduced Petitioner's pain with injections into the C5-6 and C6-7 disc levels as well as revealing damage in those discs. Dr. Lorenz explained that the discogram confirmed his diagnosis that the cervical discs were in fact the source of Petitioner's ongoing complaints. Moreover, Dr. Lorenz testified that the fall on the shoulder (not mentioning the neck) was consistent with injury to these discs. He causally related Petitioner's ongoing condition of ill-being to the fall at work. Dr. Lorenz further noted that because Petitioner also had significant arm issues after the fall, the radiculopathy could easily have been overlooked while the upper extremity was addressed. Petitioner testified that he had continuing neck region complaints and pain into his arm and hand after the fall, but the early treatment was exclusively directed at the arm rather than the neck.

In summary, the upper extremity testing, the limited success with treatment directed at the arm, the inability of the initial physicians to explain the symptoms on the basis of an arm injury and Dr. Lorenz's eventual workup of the cervical spine as the source of the problems all point to the cervical spine as a source of Petitioner's ongoing disability. The details all support the conclusion that a causal relationship exists between Petitioner's cervical spine condition of ill-being and the fall at work on December 26, 2009.

The Arbitrator notes that Respondent's independent medical examiner, Dr. Bernstein, agreed that the discogram might be an indicator that the cervical levels were pain generators. He did not dispute that a surgical recommendation would be appropriate when a patient cannot live with the pain, indicating the idea is to go in and scrape out the discs which are generating the pain. Dr. Berstein also admitted that he thought Dr. Lipov generally did good discograms and that he used Dr. Lipov for some discograms. Dr. Bernstein also agreed that falling on the shoulder and back is a competent mechanism for jarring, jostling and shifting the cervical spine. Dr. Bernstein also admitted that numbness down the entire arm following the accident could be consistent with

injury to the C5-6 and C6-7 levels. He provided that an alternative explanation might be a brachial plexus injury, but he was not aware that anyone had diagnosed Petitioner with a brachial plexus injury. He stated that if it was a brachial plexus injury, you would treat the symptoms rather than the source and an EMG/NCV might reveal damage along the nerve. Dr. Bernstein further noted that the EMG/NCV was negative in Petitioner's case and he would not expect a positive EMG result if the discs were the pain generators. Finally, while Dr. Bernstein would not concede that Petitioner's arm numbness was due to a cervical source, he admitted that he could not identify pathology to explain why Petitioner had the numbness.

Lastly, while Dr. Bernstein offered some defense to causation, he admitted the fall was a competent mechanism for injury to the cervical spine, he conceded that the discogram might be an indicator that the cervical levels were pain generators and he did not have an alternative explanation to account for Petitioner's arm numbness.

With respect 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 that Petitioner's cervical condition of ill-being is causally related, the Arbitrator finds that Respondent is responsible for the medical services provided by Hinsdale Orthopaedics Associates in the amount of $722.00 and Dr. Lipov in the amount of $7,270.00. Said medical services shall be paid consistent with the medical fee schedule. Respondent is further entitled to a credit for all medical expenses paid.

With respect to ISSUE (K.) - Is Petitioner Entitled To Any Prospective Medical Care, the Arbitrator finds as follows:

Petitioner has an outstanding prescription for decompression and fusion of C5-6 and C6-7. According to Petitioner, Dr. Lorenz performed a reevaluation in May of 2013 and the surgical recommendation remains. The earlier MRI demonstrated endplate narrowing and a disc bulge at C5-6, significant enough to flatten the ventral thecal sac. At C6-7, Petitioner had endplate spurring, evidence of bilateral stenosis with bilateral foraminal narrowing. Petitioner had been given the option of living with the pain or going through the surgery. Petitioner testified that wanted the surgery as he was no longer able to live with the pain. Petitioner currently takes Hyrdocodone and prescription Ibuprofen for pain. Dr. Lorenz also related the need for the surgery to the work accident, explaining that Petitioner had no dysfunction or pain prior to the accident and that he never fully recovered from his neck-related complaints after the accident. Respondent's IME doctor agreed that this type of surgery was done to address discs which are pain generators. (RX1 p.24) Given the findings on accident and causation, Respondent shall authorize the cervical surgery recommended by Dr. Lorenz.

With respect to ISSUE (L.) - What Temporary Benefits Are In Dispute (TTD), the Arbitrator finds as follows:

In Interstate Scaffolding v. Illinois Workers' Compensation Commission, 236 Ill. 2d 132, 923 N.E.2d 266 (2010), the Supreme Court held that an employer's obligation to pay TTD benefits to an injured employee does not cease because the employee had been discharged--whether or not the discharge was for "cause." When an injured employee has been discharged by his employer, the determinative inquiry for deciding entitlement to TTD benefits remains, as always, whether the claimant's condition has stabilized. If the injured employee is able to show that he continues to be temporarily totally disabled as a result of his work-related injury, the employee is entitled to TTD benefits. The Court also noted that TTD benefits may be suspended or terminated if the employee refuses to submit to medical, surgical, or hospital treatment essential to his recovery, or if the

employee fails to cooperate in good faith with rehabilitation efforts. Benefits may also be suspended or terminated if the employee refuses work falling within the physical restrictions prescribed by his doctor.

In this case, none of the above exceptions exist. Petitioner was working light duty prior to his termination on April 28, 2010. Respondent provided no TTD benefits even though Petitioner was restricted from any lifting with the left arm. Less than a month later, Petitioner was fully restricted by Dr. Lorenz while waiting for approval of the cervical treatment. Respondent withheld TTD, claiming that it did not owe benefits as Petitioner was fired for cause and he would have been working had he not engaged in the misconduct.

As noted in Interstate Scaffolding, the employer's obligation to pay TTD benefits to an injured employee does not cease because the employee had been discharged--whether or not the discharge was for "cause." With respect to the exceptions, there is no evidence that Petitioner refused to submit to medical, surgical, or hospital treatment essential to his recovery, or that he refused work falling within the physical restrictions prescribed by his doctor. As noted above, less than a month after Petitioner was terminated, he was fully restricted by Dr. Lorenz while waiting for approval of the cervical treatment. As of his deposition, Dr. Lorenz continued his off work restriction.

Lastly, the Interstate Scaffolding court stated, "Looking to the Act, we find that no reasonable construction of it's provisions support a finding that TTD benefits may be denied an employee who remains injured, yet has been discharged by his employer for "volitional conduct" unrelated to his injury…Such an inquiry is foreign to the Illinois workers' compensation system." The Arbitrator is not making a determination on validity of Petitioner's termination. By not doing so, the Arbitrator is not suggesting that any volitional act or conduct such as sexual harassment is acceptable.

Based on the above, the Arbitrator finds that Petitioner is entitled to TTD for the period from April 28, 2010 through August 7, 2013.

STATE OF ILLINOIS)
) SS.
COUNTY OF DU PAGE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JOSEPH CLUTTERBUCK,

Petitioner,

vs. NO: 11 WC 35487

UNITED POSTAL SERVICE,

Respondent.

15IWCC0046

DECISION AND OPINION ON REVIEW

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

The Arbitrator gave Respondent credit for $10,300.00 for non-occupational indemnity disability benefits towards temporary total disability benefits. We modify the Arbitrator's Decision and give Respondent credit of $9,182.93 towards temporary total disability benefits.

Petitioner collected short term disability benefits through Aetna while he was off work. Aetna paid $10,300.00 in benefits total, which was taxed. Petitioner received a net payment of $9,182.93 after $1,117.07 was withheld in taxes.

Section 8(j) of the Act allows Respondent to receive credit towards payments already made and states:

(j) In the event the injured employee receives benefits, including medical, surgical or hospital benefits under any group plan covering non-occupational disabilities contributed to wholly or partially by the employer, which benefits should not have been payable if any rights of recovery existed under this Act, then such amounts so paid to the employee from any such group plan as shall be consistent with, and limited to, the provisions of paragraph 2 hereof, shall be credited to or against any compensation payment for temporary total incapacity for work or any medical, surgical or hospital benefits made or to be made under this Act.

The Appellate Court has held that Respondent is only entitled to credit for the amount of money Petitioner actually received and is not entitled to credit for the total amount paid, albeit withheld in taxes. Navistar Int'l Transp. Corp. v. Industrial Comm'n (Diaz),315 Ill. App. 3d 1197, 1207-08,734 N.E.2d 900, 907,2000 Ill. App. LEXIS 533, 20-21,248 Ill. Dec. 609, 616(Ill. App. Ct. 1st Dist.2000). The Court in Navistar specifically considered the question as to whether the employer should receive credit for the gross amount paid or net amount – the actual amount received by the employee. Id. The Court made its decision based on the plain language of the statute. Id. The Court concluded: "Following the plain language of the statute, an employer should not be entitled to a credit for amounts not paid to the employee, including amounts paid to the government in withheld taxes." Id. Therefore, credit is awarded for the amount the employee actually received, not the net amount paid.

Following the Court's holding in Navistar, the Commission modifies the Arbitrator's decision to give Respondent a credit of $9,182.93, that being the difference between the amount of $10,300.00 minus $1,117.07 withheld from Petitioner for taxes.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's decision is modified as stated herein.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $1,142.51 per week for a period of 20-4/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $608.34 for medical expenses under §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $669.64 per week for a period of 86 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the 40% loss of the left leg.

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

15IWCC0046

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 $72,600.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JAN 20 2015
TJT: kg
O: 11/28/14
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CLUTTERBUCK, JOSEPH
Employee/Petitioner

Case# **11WC035487**

UPS
Employer/Respondent

15IWCC0046

On 4/30/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0412 RIDGE & DOWNES
AMYLEE HOGAN SIMONOVICH
101 N WACKER DR SUITE 200
CHICAGO, IL 60606-7307

2284 LAW OFFICE OF LAWRENCE COZZI
MARK H ZAPF
27201 BELLA VISTA PKWY STE 410
WARRENVILLE, IL 60555-1619

STATE OF ILLINOIS)
)SS.
COUNTY OF DUPAGE

15IWCC0046

☐ 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

Joseph Clutterbuck,
Employee/Petitioner

v.

UPS,
Employer/Respondent

Case # **11** WC **35487**

Consolidated cases: **none**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Peter M. O'Malley**, Arbitrator of the Commission, in the city of **Wheaton**, on **2/7/13**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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 _____

15IWCC0046

FINDINGS

On **1/20/11**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

Petitioner's current condition of ill-being, including the need for a left total knee replacement surgery ***is*** causally related to the accident.

In the year preceding the injury, Petitioner earned **$56,554.30**; the average weekly wage was **$1,713.77**.

On the date of accident, Petitioner was **58** years of age, ***married*** with **no** dependent children.

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

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

Respondent shall be given a credit of **$0.00** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$10,300.00** for non-occupational indemnity disability benefits, for a total credit of **$10,300.00**.

Respondent is entitled to a credit of **$82,835.23** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $1,142.51 per week for 20-4/7 weeks, commencing January 21, 2011 through June 13, 2011, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services in the amount of $608.34, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall be given a credit of $82,835.23 for medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $669.64 per week for 86 weeks, because the injuries sustained caused the 40% loss of the left leg, as provided in Section 8(e) of the Act.

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

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

Signature of Arbitrator

4/26/13
Date

STATEMENT OF FACTS:

Petitioner, a 58 year old feeder driver, testified that he had previously worked for UPS from 1977 through 1983. He indicated that he began working for Respondent in his current capacity in 2000. Petitioner testified that his duties as a feeder driver include driving routes, hooking up trailers, and inspecting equipment. He estimated that he gets out of his cab a minimum of 20 to 22 times a day and uses a clutch with his left leg at least 200 times a day.

Petitioner testified that on January 20, 2011 he was doing a pre-trip inspection with a new supervisor, Michelle Mahoney. At that time, he was opening the hood of his tractor from the side underneath the wheel well and felt pain in his left knee and fell to the ground. In an "Injury Prevention Report" dated January 20, 2011 it was noted that Petitioner "… was starting to lift up the tractor hood when his knee went out and he fell." (PX1).

Following the incident Petitioner was taken to the Clearing Clinic/MacNeal Occupational Health Services where he reported "lifting hood of tractor under wheel well as prescribed left knee gave out <sharp pain> instantaneously." (PX2). X-rays of his knee revealed no acute bony abnormalities, tricompartmental degenerative osteoarthritis and small joint effusion. (PX2). Petitioner was diagnosed with a sprain/strain and referred to an orthopedist. (PX2).

Petitioner elected to visit Dr. Kevin Walsh with whom he had previously treated. In fact, Dr. Walsh had performed a ***right*** knee replacement on Petitioner approximately seven (7) months earlier on June 23, 2010. Petitioner also acknowledged that he had previously undergone arthroscopic surgery on his ***left*** knee in 1996.

With respect to this prior history, Dr. Walsh's records show that on June 7, 2010 Petitioner presented with complaints of pain and discomfort in his right knee. (PX2). Dr. Walsh noted a "very complex history" wherein Petitioner underwent hammertoe repair in April 2010 and thereafter developed a DVT. (PX2). Dr. Walsh indicated that Petitioner had been "… pretty much bedbound since his DVT and now has developed significant pain and swelling in his right knee. He was told he has gout, although no crystals were seen." (PX2). X-rays of the right knee revealed severe osteoarthritis in the lateral compartment with bone-on-bone changes. (PX2). Dr. Walsh noted that he "… told the patient and his wife that the immobilization in the postoperative period has probably caused a flare-up of osteoarthritis." (PX2). Dr. Walsh discussed several treatment options, noting that Petitioner "… knows the knee replacements [sic] is the only definitive treatment for the osteoarthritis and he is anxious to proceed with surgery." (PX2). Dr. Walsh also noted that Petitioner "… thinks this is work-related and he is considering filing a claim." (PX2). The Arbitrator notes that Petitioner testified at arbitration that his previous right knee injury was not the result of an accident. Finally, Dr. Walsh noted that "[i]f he wishes to have surgery, he will contact our office and we can perform a right knee replacement for him at his convenience at Edward Hospital on any given Friday assuming we have medical clearance." (PX2).

As previously mentioned, Petitioner ultimately underwent a right total knee replacement on June 23, 2010. (PX2).

In a note dated July 6, 2010 Dr. Walsh indicated that Petitioner had been discharged from Marianjoy and was getting home therapy for his right knee following surgery. (PX2). This note went on to say that Petitioner "… is bothered mostly by pain and instability in his left knee. While in the hospital he did have an x-ray of the left knee. He does have severe osteoarthritis in the lateral compartment. He probably had a gouty attack while in the hospital as well… If his left knee symptoms persist, he plans to have a left knee replacement but hopes to wait until 2011. Hopefully we can keep his pain under control with an occasional injection of corticosteroid or viscosupplements." (PX2).

Dr. Walsh testified that at the time of his examination on July 6, 2010, or approximately two (2) weeks post surgery on the right knee, Petitioner complained of pain and instability of the left knee. (PX5, p.11). Dr. Walsh noted that Petitioner had never mentioned pain or instability in the left knee prior to that time, and that it was the first time he noticed any effusion in the left leg. (PX5, p.11). Dr. Walsh testified that the plan of treatment for the left knee at that time was that "... if the patient's symptoms persisted he would plan on having a left knee replacement but hoped to wait until 2011." (PX5, pp.11-12). Dr. Walsh agreed that he did not make a prescription for any left knee replacement at that time, noting that "[h]opefully his knee would settle down, his left knee." (PX5, p.12). Dr. Walsh also indicated that "[a]ll his medications were for his right knee" at that time. (PX5, pp.12-13). However, on cross examination, Dr. Walsh conceded that at this point Petitioner "certainly ha[d] radiographic evidence of end-stage osteoarthritis. Whether a patient has a knee replacement or not depends on their symptoms. But certainly he ha[d] objective evidence of end-stage osteoarthritis ..." (PX5, pp.33-34).

Petitioner agreed that he first related complaints relative to his left knee on July 7, 2010. He indicated that at that time he discussed options with Dr. Walsh concerning the left knee. However, he noted that he received no treatment for the left knee at that time. He did acknowledge that he was taking pain medication at that time for his left knee in the form of Celebrex for what he believed was a gout attack. He indicated that he thereupon cut down on pizza and red meat and that the gout ultimately resolved.

In an office note dated August 9, 2010 Dr. Walsh noted that Petitioner was "... very happy with his (right TKR) outcome. He is taking pain medicine mostly for his opposite left knee where he does have severe osteoarthritis in the lateral compartment. He does have a history of gout as well. He has been taking Celebrex and his gout has been controlled... He may be moving to Atlanta in the near future. He has had some relatives who recently became quite ill. He is considering having his surgery moved up prior to his move to Atlanta. He can certainly notify us if he wishes to have surgical intervention for his left knee. A knee replacement would be in his best interest. In the meantime, he will continue his rehabilitation. He is scheduled to return to work on September 1, 2010... If he elects to have his left knee replaced in the future, a new standing AP, lateral, and skyline view of his left knee will be necessary." (Emphasis added) (PX2).

Dr. Walsh testified that at the time of this visit Petitioner indicated that he was considering moving to Atlanta, and that he was thinking of moving up his left knee replacement to the spring of 2011 as a result. (PX5, pp.14, 34). Dr. Walsh agreed that when they parted ways on that day Petitioner was to get back to him if he wanted further treatment for his left leg. (PX5, p.14). Dr. Walsh also indicated that he did not make a prescription for a left knee replacement at that time. (PX5, p.14). However, Dr. Walsh later agreed that at the time of this August 9, 2010 visit he believed a left knee replacement would be in Petitioner's best interest, and that it would be a permanent fix for his condition. (PX5, pp.35, 43).

Petitioner could not recall Dr. Walsh saying that a left total knee replacement was in his best interest. Petitioner also denied telling Dr. Walsh that he may be moving to Atlanta and that he was considering moving up his surgery.

Petitioner was eventually discharged from treatment with respect to his right knee by Dr. Walsh on September 13, 2010. In an office note on that date Dr. Walsh indicated that Petitioner "... is very pleased with the outcome of the (right knee) operation..." and that "[h]e reports that he is not taking anything for pain. He does report that the left knee is bothering him as well and he is thinking about having that knee replaced in the spring." (PX2). Dr. Walsh concluded that Petitioner did not have to follow up with respect to the right knee, unless he was having problems, and that Mr. Clutterbuck "... may follow up for the left knee when he decides to have that one taken care of." (PX2).

Dr. Walsh testified that at the time of this September 13, 2010 visit Petitioner "... did report the left knee was bothering him as well and he was thinking about having it replaced in the spring, but all the treatment [at that time] was to the right knee." (PX5, p.15). Dr. Walsh also noted that Petitioner indicated he was not taking anything for pain at that time. (PX5, p.15).

Petitioner agreed that the possibility of a left total knee replacement was discussed at the time of this September 13, 2010 visit, or approximately four (4) months before the accident in question, but that it was not conclusive as to when. In fact, he testified that prior to the date of the accident he was not planning on having his left knee replaced and that he had no definitive plans to do so until after he saw his doctor. He likewise noted that he was not taking any medication at the time of the incident for either knee and that his gout had resolved. Petitioner testified that between September 13, 2010 and the date of the accident on January 20, 2011 his left knee was fairly normal, other than creaks and such. He indicated that he had some swelling but that he rarely took pain medication. He also denied any instability or giving out of the left knee during this time. Petitioner noted that he worked full duty up to the date of the accident and that he had no need to relate any complaints to Dr. Walsh prior to that date.

Petitioner indicated that following the incident on January 20, 2011 he had pain and instability in the left leg and could not put weight or pressure on it. He visited Dr. Walsh on January 24, 2011. On that date Dr. Walsh recorded that Petitioner's left knee pain began on January 20, 2011 when he was lifting the hood of a semi under the wheel well and "... he felt an extreme amount of pain in the knee, which caused him to fall." (PX2). Dr. Walsh noted that the x-rays taken at the urgent care facility "... showed severe degenerative changes of the left knee most notable in the lateral compartment." (PX2). Dr. Walsh noted that "[a]t this point, we are going to try to get a total knee replacement approved by the workers' compensation carrier. He wants to have this surgery performed as soon as possible... In the meantime, he will remain off work until he has recovered from his knee replacement surgery..." (PX2).

Dr. Walsh testified that at the time of his examination on January 24, 2011 he noted full extension of the left knee with a significant amount of pain with flexion over 110 degrees, a valgus deformity and no ligamentous instability. (PX5, p.18). Dr. Walsh also noted crepitation with flexion and extension and along with tenderness to palpation over the medial joint line, both of which he agreed had not been previously noted in his records. (PX5, pp.18-19). Dr. Walsh noted that he was unable to perform a McMurray or Apley Grind Test due to pain. (PX5, pp.18-20). Dr. Walsh agreed that it was after this examination that he first prescribed any medication to Mr. Clutterbuck to treat his left leg. (PX5, p.20).

Petitioner eventually underwent a left cemented total knee replacement at the hands of Dr. Walsh on March 19, 2011. (PX2). The pre and post operative diagnosis was severe osteoarthritis left knee with genu valgum deformity, status post right total knee replacement. (PX2). During his deposition, Dr. Walsh agreed that surgery had revealed bone-on-bone findings which he indicated would have preexisted the accident. (PX5, p.36).

Petitioner testified that Dr. Walsh eventually released him to return to regular duty on June 27, 2011 following physical therapy for his left knee. He indicated that he had no reason to dispute the records of Athletico if they show he was released by that facility on June 13, 2011. He also noted that his group health provider paid the majority of his medical bills and that he received disability benefits as well.

In an office note dated June 27, 2011, Dr. Walsh noted that Petitioner reported that "... he is doing very well. He is very pleased with the outcome of the operation. He is back at work and finished with physical therapy. He does report an occasional clicking sensation in the knee but reports no significant pain with clicking

sensation." (PX3). Dr. Walsh indicated that Petitioner could continue with activities as tolerated and instructed him to follow up on an as needed basis. (PX3).

Dr. Walsh testified by way of evidence deposition on October 29, 2012. Dr. Walsh agreed that there was no prescription by him to perform the left knee replacement before the January 2011 accident, and that Petitioner "... was discharged in 2010 and advised to return to see me if and when he decided to have a left knee replacement." (PX5, p.27). Dr. Walsh later indicated that "[t]here were no formal plans to do anything. The patient was hoping to wait until 2011 to have a knee replacement; and he was to contact us if, indeed, he wanted to proceed with that sort of surgery at a time that was convenient for him." (PX5, p.41). Later still, Dr. Walsh testified that "[t]he indication for a knee replacement would be the patient's complaint of pain. If the patient has no pain, then we don't operate on them no matter what the x-ray shows." (PX5, p.42). Dr. Walsh also indicated that "[s]ome patients will say they plan to have surgery in the future and then actually end up never having surgery. So it is somewhat speculation whether they're going to have surgery or not." (PX5, p.44).

In addition, Dr. Walsh testified that "[c]ertainly any sort of repetitive forceful, jarring activities [such as operating a clutch as a truck driver], can contribute to osteoarthritis in the knee joint." (PX5, pp.26-27). However, Dr. Walsh also agreed that Petitioner had been diagnosed with gout and that "[m]ore likely than not [it was] a contributing factor to his osteoarthritis. His osteoarthritis is probably multifactorial, but gout can certainly cause gouty arthritis, especially if you have recurrent episodes of gout in your knee joints", which he noted Mr. Clutterbuck had probably had in the past. (PX5, pp.30-31). In addition, Dr. Walsh noted that Petitioner had a valgus deformity, or was knock-kneed, which he stated "... can lead to premature wear on the outside of the knee, outer compartment of the knee and lead to osteoarthritis and ultimate knee replacement." (PX5, pp.31-32).

At the request of Respondent, a records review was conducted by board certified orthopedic surgeon Dr. Ryon Hennessy. Dr. Hennessy noted that the records revealed Petitioner had previously undergone an arthroscopy of the left knee in the 1990's and eventually presented to Dr. Mash in August of 2007 with complaints relative to his right knee. (RX5, p.10). Dr. Hennessy indicated that in an office note dated August 28, 2007 Dr. Mash had noted effusion in both knees and that Petitioner suffered from underlying osteoarthritic change in both knees at that time. (RX5, pp.10-11). Dr. Hennessy pointed out that there was a gap in the records until May of 2008 when Petitioner was noted to have developed a left foot drop, the etiology of which was never really clear, and that the notes from that visit show "... a moderate effusion and osteoarthritis of the left knee ..." (RX5, p.11). Dr. Hennessy stated that Petitioner eventually visited Dr. Walsh with right knee complaints following hammertoe surgery in April of 2010. (RX5, p.12). At that time a history of gout was also noted. (RX5, p.12). Dr. Hennessy indicated that gout crystals cause inflammation that "... over time eat away at the cartilage surfaces themselves, so it actually can cause arthritis or hasten preexisting arthritis." (RX5, pp.12-13).

Dr. Hennessy testified that Petitioner eventually had a right knee replacement in June of 2010, the operative report for which noted findings of osteoarthritis and a thickened synovium, which he indicated was consistent with chronic gout. (RX5, p.13). Dr. Hennessy stated that Petitioner thereupon underwent rehabilitation and was diagnosed with severe osteoarthritis of both knees. (RX5, p.13). Dr. Hennessy agreed that Petitioner could have had an altered gait following this procedure and that this altered gait with respect to the right knee could have affected the left knee. (RX5, p.21). Furthermore, Dr. Hennessy indicated that x-rays of the left knee performed on June 26, 2010 showed bone on bone degenerative changes in the lateral and patellofemoral compartments as well as osteophytes in all three compartments, including the medial compartment. (RX5, pp.22-23). Dr. Hennessy opined that these x-rays confirmed the diagnosis of severe osteoarthritis. (RX5, p.14). Dr. Hennessy also noted that Petitioner complained of pain and instability of the left knee roughly two (2) weeks after replacing the right knee, which Dr. Walsh apparently thought was perhaps from the gouty attack. (RX5, p.14).

Dr. Hennessy indicated that Dr. Walsh first mentioned the possibility of a total left knee replacement in a note dated July 6, 2010, noting that the patient hoped to wait until 2011. (RX5, pp.14-15). Dr. Hennessy noted that Dr. Walsh reiterated his opinion in office notes dated August 9, 2010 and September 13, 2010 to the effect that a left total knee replacement was in Petitioner's "best interest" and that the patient was thinking of having the procedure done in the spring of 2011. (RX5, pp.15-16).

Dr. Hennessy indicated that Petitioner eventually underwent a left total knee replacement on March 30, 2011, and that the operative report revealed severe osteoarthritic disease in the lateral compartment with eburnated bone present over the entire lateral half of the lateral femoral condyle, meaning that "… not only has the cartilage been worn away from the bone but the bone cartilage had been gone so long that the bone had actually somewhat polished itself." (RX5, p.19). Dr. Hennessy also noted that the surgical report revealed gouty crystals throughout the knee joint. (RX5, p.19).

Based on his review of the record, Dr. Hennessy was of the opinion that Petitioner suffered a minor sprain as a result of the January 20, 2011 work incident and that "… the medical records do not purport any way that the [left] knee replacement was related to a minor – a minor sprain to his knee." (RX5, p.24). Dr. Hennessy went on to opine that the work accident "… did not exacerbate the osteoarthritis. It was already severe in two compartments. It did not accelerate his need for a knee replacement as he was planning to have a knee replacement in the spring of 2011, which is exactly what happened." (RX5, p.24). Dr. Hennessy also pointed out that Dr. Walsh had already recommended a total knee replacement for the left knee on several visits and that "[not] only was he recommending it but Mr. Clutterbuck himself wanted to do it. It was more of a matter of when, not if." (RX5, pp.24-25).

Dr. Walsh reviewed Dr. Hennessy's report and noted that he agreed with the latter "… that more likely than not the injury of January 2011 did not accelerate the patient's osteoarthritis, but I do believe it exacerbated symptoms with that event. He had extreme pain and he indicated to the physician assistant that it caused him to fall. So I would say more likely than not that caused an exacerbation of his preexisting condition that cause [sic] him to sense instability. Caused him to need a knee replacement and that surgery was moved up in an accelerated fashion because of that work-related event." (PX5, p.28). Dr. Walsh went on to state that "[p]rior to January 2011, he was not scheduled for any knee replacement. Afterwards, the patient wanted to have surgery. He was afraid he would have another instability episode and have that extreme sort of pain. It was clear he was able to return to work after the right knee replacement. He was working without any formal restrictions on my part. And I do believe the event of January 2011 accelerated the need for a knee replacement and exacerbated the underlying condition. And then another opinion is prolonged work at UPS could be a cause of the patient developing osteoarthritis in his knees. Knee replacement can be related to, obviously, repetitive strenuous, heavy-duty type occupations." (PX5, pp.28-29).

Petitioner testified that he is presently still working for Respondent as a feeder driver, only on a different route, and that he does not have any work restrictions with respect to his left knee. He noted that he currently notices a little bit of stiffness and tightness in his left knee, which is why he got a smaller route. He also stated that he experiences a little bit of pain in his left knee, but "nothing earth shattering." He indicated that he does not take any medication for his pain. He did note, however, that he changed out the chair he sits in to watch TV given the difficulty he was having getting out of a lower chair, and sold off his motorcycle for fear of dropping the bike and not being able to get home is his leg locked up on him. He noted that he did not have these issues after undergoing the right knee replacement, which he noted was "fine."

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

It has long been recognized that, in preexisting condition cases, recovery will depend on the employee's ability to show that a work-related accidental injury aggravated or accelerated the preexisting disease such that the employee's current condition of ill-being can be said to have been causally-connected to the work-related injury and not simply the result of a normal degenerative process of the preexisting condition. *Sisbro, Inc. v. Industrial Commission*, 207 Ill. 2d 193, 204-206, 797 N.E.2d 665, ___, 278 Ill.Dec. 70, ___ (2003); citing *Caterpillar Tractor Co. v. Industrial Commission*, 92 Ill. 2d 30, 36-37, 65 Ill. Dec. 6, 440 N.E.2d 861 (1982); *Caradco Window & Door v. Industrial Comm'n*, 86 Ill. 2d 92, 99, 56 Ill. Dec. 1, 427 N.E.2d 81 (1981); *Azzarelli Construction Co. v. Industrial Comm'n*, 84 Ill. 2d 262, 266, 49 Ill. Dec. 702, 418 N.E.2d 722 (1981); *Fitrro v. Industrial Comm'n*, 377 Ill. 532, 537, 37 N.E.2d 161 (1941).

It is axiomatic that employers take their employees as they find them. *Sisbro, Inc.*, 207 Ill.2d at 205; citing *Baggett v. Industrial Comm'n, 201 Ill. 2d187, 199, 266 Ill. Dec. 836, 775 N.E.2d 908 (2002).* "When workers' physical structures, diseased or not, give way under the stress of their usual tasks, the law views it as an accident arising out of and in the course of employment." *General Electric Co. v. Industrial Comm'n*, 89 Ill. 2d 432, 434, 60 Ill. Dec. 629, 433 N.E.2d 671 (1982). Thus, even though an employee has a preexisting condition which may make him more vulnerable to injury, recovery for an accidental injury will not be denied as long as it can be shown that the employment was also a causative factor. *Caterpillar Tractor Co. v. Industrial Comm'n*, 92 Ill. 2d at 36; *Williams v. Industrial Comm'n*, 85 Ill. 2d 117, 122, 51 Ill. Dec. 685, 421 N.E.2d 193 (1981). Accidental injury need not be the sole causative factor, or even the primary causative factor, as long as it was a causative factor in the resulting condition of ill-being. *Rock Road Construction Co. v. Industrial Comm'n*, 37 Ill. 2d 123, 127, 227 N.E.2d 65 (1967).

Whether a claimant's disability is attributable solely to a degenerative process of the preexisting condition or to an aggravation or acceleration of a preexisting condition because of an accident is a factual determination to be decided by the Industrial Commission. *Roberts v. Industrial Comm'n*, 93Ill. 2d 532, 538, 67 Ill. Dec. 836, 445 N.E.2d 316 (1983); *Caterpillar Tractor Co. v. Industrial Comm'n*, 92 Ill. 2d at 36-37; *Caradco Window & Door v. Industrial Comm'n*, 86 Ill. 2d 92, 99, 56 Ill. Dec. 1, 427 N.E.2d 81 (1981).

"When an employee with a preexisting condition is injured in the course of his employment, serious questions are raised about the genesis of the injury and the resulting disability. The Commission must decide whether there was an accidental injury which arose out of the employment, whether the accidental injury aggravated or accelerated the preexisting condition or whether the preexisting condition alone was the cause of the injury. Generally, these will be factual questions to be resolved by the Commission. However, the Commission's decision must be supported by the record and not based on mere speculation or conjecture. If there is an adequate basis for finding that an occupational activity aggravated or accelerated a preexisting condition, and, thereby, caused the disability, the Commission's award of compensation must be confirmed." *Sisbro, Inc.*, 207 Ill.2d at 215.

In the present case, the question is whether the accident at work on January 20, 2011 aggravated or accelerated the preexisting condition, or whether the preexisting condition alone was the cause of the injury and the need for left total knee replacement surgery.

There is no question that Petitioner had a severely compromised and problematic left knee, due primarily to his underlying osteoarthritis, complicated no doubt by a history of gouty attacks and valgus deformity. It is likewise

undisputed that Dr. Walsh, his treating orthopedic surgeon, had advised Petitioner that a left total knee replacement would be in Mr. Clutterbuck's best interest a full five (5) month's before the accident in question.

However, it is equally clear that Dr. Walsh had not formally prescribed said surgery, a detail borne out by the fact that no such procedure was scheduled prior to the accident. Instead, he released Petitioner to return to work following the right TKR with the admonition to return when and if he was ready to have the left knee done, an open ended invitation that Dr. Walsh noted some patients never take him up on. In fact, if Petitioner's pain remained manageable, there would have been no need to undergo the procedure, at least as soon as he did, given Dr. Walsh's statement that "[t]he indication for a knee replacement would be the patient's complaint of pain. If the patient has no pain, then we don't operate on them no matter what the x-ray shows." (PX5, p.42).

Indeed, other than several passing references to the possibility of moving the surgery up to the spring of 2011, which Petitioner denied, there is absolutely no indication that the left TKR was eminent. On the contrary, Petitioner appeared to be functioning more than adequately, having worked the ensuing four (4) months in his regular duty capacity as a feeder truck driver without restrictions and without the need for any prescription pain medication, much less a reason to return to Dr. Walsh, until after the accident on January 20, 2011.

More to the point, it was only after the incident at work that the need for surgery turned from an eventuality to a pressing need. Along these lines, Dr. Walsh testified that while the January 2011 injury did not "accelerate the patient's osteoarthritis" he believed that the event "...more likely than not ... caused an exacerbation of his preexisting condition that cause [sic] him to sense instability. Caused him to need a knee replacement and that surgery was moved up in an accelerated fashion because of that work-related event." (PX5, p.28). Thus, it would appear that the accident in question, at the very least, accelerated the need for the left total knee replacement.

But one question remains – namely, whether Petitioner's condition was so far gone that any activity would have brought upon the need for the surgery? The court in *Sisbro* addressed a similar situation in its opinion, or what it described as the "normal daily activity exception" to the general rule that an employee need only prove that some act or phase of the employment was a causative factor in the resulting injury. Along these lines, the *Sisbro* court emphatically pointed out that "[w]e have never found a causal connection to exist between work and injury and then, in a further analytical step, denied recovery based on a 'normal daily activity exception' or a 'greater risk exception.'" *Sisbro, Inc.*, 207 Ill.2d at 212. The point being, the injury was either aggravated or accelerated by the work incident, or else the pre-existing condition alone was the cause of the injury. As already determined, the accident in the present case accelerated the need for surgery, and as such the analysis effectively ends there.

Therefore, based on the above, and the record taken as a whole, the Arbitrator finds that Petitioner's current condition of ill-being, including the need for the left total knee replacement surgery, is causally related to the undisputed accident on January 20, 2011.

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 agreed that Respondent's group health insurance plan paid $82,835.23 in medical benefits in relation to this claim. (Arb.Ex.#1).

In addition to those bills already paid, Petitioner submitted into evidence the following out of pocket expenses:

1. DuPage Medical Group		$116.94
2. Illinois Medicar		$36.00
3. Winfield Laboratory Consultants		$3.60
4. Rehabilitation Medicine Clinic		$85.10
5. AthletiCo		$337.20
6. Prescriptions		$25.00
7. Winfield Radiology		$4.50
	TOTAL:	$608.34

Based on the above, and the record taken as a whole, as well as the Arbitrator's determination as to causation (issue "F", supra), the Arbitrator finds that Petitioner is entitled to out of pocket expenses totaling 608.34, pursuant to §8(a) and the fee schedule provisions of §8.2 of the Act. The Arbitrator further finds that the Respondent is entitled to a credit in the amount of $82,835.23 for benefits previously paid through its group carrier, and that Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving said credit pursuant to §8(j) of the Act.

WITH RESPECT TO ISSUE (K), WHAT AMOUNT OF COMPENSATION IS DUE FOR TEMPORARY TOTAL DISABILITY, THE ARBITRATOR FINDS AS FOLLOWS:

The record reveals that Petitioner was initially given restrictions by the company clinic and was eventually authorized off completely pending left total knee replacement and rehabilitation. Following surgery on his left knee on March 19, 2011, Petitioner underwent a program of physical therapy at Athletico. (PX2). Petitioner testified that Dr. Walsh eventually released him to return to regular duty on June 27, 2011.

However, in an office note dated June 27, 2011, Dr. Walsh noted, before releasing Mr. Clutterbuck to follow up on an as-needed basis, that Petitioner "… [was] back at work and [had] finished with physical therapy…" (PX3). Along these lines, Petitioner testified that he had no reason to dispute the records of Athletico if they show he was released by that facility on June 13, 2011.

Therefore, based on the above, and the record taken as a whole, as well as the Arbitrator's determination as to causation (issue "F", supra), the Arbitrator finds that Petitioner was temporarily totally disabled from January 21, 2011 through June 13, 2011, for a period of 20-4/7 weeks. The Arbitrator also notes that the parties stipulated Respondent paid $10,300.00 in non-occupational disability benefits as a result of this injury, and that Respondent shall be entitled to a credit for same. (Arb.Ex.#1).

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

Petitioner underwent a left cemented total knee replacement at the hands of Dr. Walsh on March 19, 2011. (PX2). The pre and post operative diagnosis was severe osteoarthritis left knee with genu valgum deformity, status post right total knee replacement. (PX2).

Following surgery, Petitioner participated in a program at Athletico and was eventually released from the program on June 13, 2011.

In an office note dated June 27, 2011, Dr. Walsh noted that Petitioner reported that "… he is doing very well. He is very pleased with the outcome of the operation. He is back at work and finished with physical therapy. He does report an occasional clicking sensation in the knee but reports no significant pain with clicking sensation." (PX3). Dr. Walsh indicated that Petitioner could continue with activities as tolerated and instructed him to follow up on an as needed basis. (PX3).

Petitioner testified that he is presently still working for Respondent as a feeder driver, only on a different route, and that he does not have any work restrictions with respect to his left knee. He noted that he currently notices a little bit of stiffness and tightness in his left knee, which is why he got a smaller route. He also stated that he experiences a little bit of pain in his left knee, but "nothing earth shattering." He indicated that he does not take any medication for his pain. He did note, however, that he changed out the chair he sits in to watch TV given the difficulty he was having getting out of a lower chair, and sold off his motorcycle for fear of dropping the bike and not being able to get home is his leg locked up on him. He noted that he did not have these issues after undergoing the right knee replacement, which he noted was "fine." Petitioner is currently working without restriction.

Based on the above, and the record taken as a whole, the Arbitrator finds that Petitioner suffered the permanent partial loss of use of 40% of his left leg pursuant to §8(e)12 of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

- ☐ 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

JOSE A. MARQUEZ,

Petitioner,

vs.

NO: 09 WC 08273

GRECO CONTRACTORS, INC.,

15IWCC0047

Respondent.

DECISION AND OPINION ON REVIEW

This matter comes before the Commission on Petitioner's Petition for Review appealing the Arbitrator's denial of Petitioner's Motion to Reinstate. A copy of the Arbitrator's "Order of Dismiss Case for Want of Prosecution" is attached.

Petitioner filed an Application for Adjustment of Claim in February 2009 claiming he fractured his ribs and injured his back after falling and being struck by equipment. A final trial date was set for March 12, 2013. A trial letter was sent to Petitioner, but he never received it as he had moved. Petitioner was not present on March 12, 2013 and the matter was dismissed a second time. Petitioner's counsel failed to receive a notice of dismissal as the Commission data base listed Petitioner's prior attorney as the attorney of record.

On May 28, 2013, Petitioner's attorney filed a timely Motion to Reinstate. Due to an error by Petitioner's attorney's clerk no hearing date was received. The Motion was re-motioned on July 10, 2013. It was not a new Motion to Reinstate but a re-motioning of the original file. Again the clerk for Petitioner's attorney was unable to obtain a hearing date and the Motion was re-motioned for August 12, 2013. The matter was originally set for hearing on September 27, 2013; however, opposing counsel failed to appear. The matter was again re-set for October 15, 2013.

On October 15, 2013, the Arbitrator held a hearing on Petitioner's Motion to Reinstate and denied the Motion. The Arbitrator explained the Commission file does not have the May 28, 2013 or July 10, 2013 Motions and was just presented with the August 12, 2013 Motion so she did not consider that Motion timely filed.

We reverse the Arbitrator and grant Petitioner's Motion to Reinstate. While the case was dismissed with prejudice on March 12, 2013, Petitioner's attorney did not become aware of the dismissal until April 12, 2013 when he checked the Commission's website. Petitioner's attorney was not made aware of the dismissal until a later date because he was not listed as the attorney of record in the Commission's database. Petitioner's attorney showed that he correctly filed the necessary documents to be listed as the attorney of record but it was not properly entered by the Commission. Petitioner's Motion to Reinstate was first filed on May 28, 2013, as reflected on the Commission's mainframe, and thus filed within 60 days of notice of the dismissal and timely filed.

We disagree with the Arbitrator's reasoning that because only the August 12, 2013 Motion to Reinstate was in the file and not the other two previously filed Motions, the Motion was not timely. However, as is well known by the Commission, motions and other filings often are not properly added to the case folder. The Commission's data base reflects that the Motion to Reinstate was first filed on May 28, 2013, and Petitioner's attorney produced a file stamped copy of the originally filed Motion to Reinstate. That the Motion was not properly included in the case folder is not be a valid reason to deny the Motion.

The case at hand is similar to *Sanchez v. Pheasant Run*, 2010 IWCC 286. In that case and the one at hand, the Motion to Reinstate was timely filed but the case was not set immediately and properly set for hearing due to a clerical error. In this case the Motion to Reinstate was filed two additional times until it was properly set for hearing. The Commission in *Sanchez* found "Under these circumstances, the Commission considers the refusal to reinstate the case, thereby extinguishing Petitioner's claim completely, too harsh a sanction for Petitioner's tardiness and his attorney's apparent clerical error. Therefore the Commission reverses the Decision of the Arbitrator and reinstates this claim." We agree that dismissing the case is too harsh a sanction.

Therefore, we reverse the Arbitrator and grant Petitioner's Motion to Reinstate.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's Petition to Reinstate is granted.

15IWCC0047

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: JAN 20 2015
TJT: kgg
R: 11/18/14
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSTATION COMMISSION
ORDER OF DISMISS CASE FOR WANT OF PROSECUTION

ttention. The parties have 60 days from the receipt of this order to file a Petition to Reinstate Case.

MARQUEZ, JOSE
Employee/Petitioner

Case# 09WC008273

GRECO CONTRACTORS INC
Employer/Respondent

15IWCC0047

After this case was filed by the petitioner, all parties received due notice, but the petitioner failed to appear at a status call or trial date. Accordingly, as provided by law, I order that this case is dismissed for want of prosecution.

Honorable Barbara Flores

3/12/2013
Date

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

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

vs. No. 12 INC 0342

Leon Jackson, Individually and President,
Janice Sidney, Individually and Secretary,
and The Woodlawn Organization,
Respondent.

15IWCC0048

DECISION AND OPINION REGARDING INSURANCE COMPLIANCE

Petitioner, the Illinois Workers' Compensation Commission, Insurance Compliance Division, brings this action, by and through the office of the Illinois Attorney General, against the above captioned Respondents, alleging violations of Section 4(a) of the Illinois Workers' Compensation Act.

Proper and timely notice was provided to the Respondents and a bifurcated hearing was held before Commissioner Donohoo in Chicago, Illinois on March 18, 2014 and September 10, 2014. Mr. James Taylor, attorney of record for Respondents, was served timely and proper notice. (PX11). No one appeared on behalf of Respondents at either hearing date.

Petitioner alleges that Respondent knowingly and willfully lacked workers' compensation insurance coverage in violation of the requirements of Section 4(a) of the Act from May 11, 2010 through December 1, 2010, and again from December 2, 2011 through January 18, 2012. Petitioner seeks the maximum fine allowed under the Act, $500.00 per day for each of the 253 days Respondent did business and failed to provide coverage for its employees, in addition to the value of the insurance premium Woodlawn Organization saved by not providing insurance for its employees. Petitioner seeks a total fine of $217,468.00.

The Commission, after having considered the entire record, finds that Respondents willfully and knowingly violated Section 4(a) of the Act for the reasons set forth below.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

1. Petitioner presented Don Johnson, investigator for the Insurance Compliance Division of the Workers' Compensation Commission, as a witness at hearing on March 18, 2014 and September 10, 2014. Mr. Johnson testified he has worked for the Commission as an investigator for six years and his duties include enforcing the Act by making contact with employers who do not have proper workers' compensation insurance and ensuring they obtain coverage for their employees. (3/18/14 Tr.7).

2. Investigator Johnson testified that Respondent Woodlawn Organization has also been known as Woodlawn Community Development. (3/18/14 Tr. 8). After initiating an insurance compliance investigation, Mr. Johnson and another investigator, Mr. Capuzi, found three locations for Woodlawn Organization: one on South Harper Street and two on East 63rd Street in the city of Chicago. (3/18/14 Tr. 9).

3. Mr. Johnson testified that his department was notified that a person filed an Application for Adjustment of Claim for an alleged injury arising out of and in the course of employment with Respondent. (3/18/14 Tr. 8). Mr. Johnson testified it was his understanding the employee alleged he was shot while working, and Respondent did not possess workers' compensation insurance at the time of the alleged injury. (3/18/14 Tr. 8).

4. Investigators Johnson testified that he and Mr. Capuzi went to Respondent's location on East 63rd Street and photographed a van with the writing "Woodlawn Organization" painted on the side. (3/18/14 Tr. 9; PX12). Mr. Johnson further testified that he observed approximately five people inside the Woodlawn Organization office when he went in to serve the business with a Notice of Non-Compliance. (3/18/14 Tr. 9).

5. The Insurance Compliance Department requested workers' compensation insurance information for Respondent from the National Council of Compliance Insurance (NCCI). (3/18/14 Tr. 14-15). NCCI investigated Respondent and certified that Woodlawn Organization did not have workers' compensation insurance for the periods May 11, 2010 through December 1, 2010 and December 2, 2011 through January 18, 2012. (3/18/14 Tr. 15, PX4). NCCI further certified that neither Leon Jackson nor Janice Sidney obtained a policy for those periods. (PX4).

6. The Department of Self-Insurance conducted an investigation and provided a Certificate of Finding that Woodlawn Organization was not self-insured within the State of Illinois at any time. (PX7).

7. Mr. Johnson testified that, after investigation, he determined Respondent did have appropriate workers' compensation insurance for the approximately one year period between December 2, 2010 to December 1, 2011. (3/18/14 Tr. 23).

8. Investigator Johnson served Respondent with a Notice of Non-Compliance on August 28, 2012 at approximately 10:30 a.m. for the periods from May 11, 2010 through December 1, 2010 and December 2, 2011 through January 18, 2012. (3/18/14 Tr. 11, PX1). Investigator Johnson also served a second Notice of Non-Compliance for the same periods on April 19, 2012. (3/18/14 Tr. 11, PX2). A third notice for the same periods was served on Respondent by Investigator Johnson on November 7, 2012. (3/18/14 Tr. 12, PX3).

9. Investigator Johnson testified that the Insurance Compliance Department of the Commission made a good faith effort to negotiate a settlement with Respondent. An initial agreement for payment of a fine in addition to costs associated with injury to the worker was reached between the Commission and Respondent's counsel, but the settlement agreement was never finalized. (3/18/14 Tr. 13).

10. Despite requests to do so, Respondents never provided the Commission with proof they possessed workers' compensation insurance for any of the alleged periods of non-compliance. (3/18/14 Tr. 13).

11. Investigator Johnson testified he determined there was an additional period of time Respondent did not have workers' compensation insurance from May 16, 2012 until August of 2012. (9/10/14 Tr. 8).

12. Mr. Johnson testified that Respondent's last workers' compensation insurance yearly premium paid was $90,968.00. (9/10/14 Tr. 7).

13. Woodlawn Organization is registered as a not-for-profit corporation with the Illinois Secretary of State. Articles of Incorporation were filed in 1962 and in evidence are annual reports from 2009, 2010, 2011 and 2012. (3/18/14 Tr. 19, PX8). On May 28, 2010, officers for Woodlawn Organization on file with the Secretary of State were Janice Sidney as Secretary and Leon Jackson as Director. (PX8). On April 15, 2011, Leon Jackson was named as President of the Corporation and Janice Sidney was named as Secretary. (PX8).

14. The Illinois Department of Revenue provided certified records showing Woodlawn Organization had a substantial income stream from at least September 30, 2005 through January 26, 2011. (PX5). On January 26, 2011, a date within the period of non-compliance, Respondent reported a total compensation subject to withholding of $597,456.84. (PX5).

15. Investigator Johnson testified that Woodlawn Organization was set up to be a community development organization and was 100% federally funded. (3/18/14 Tr. 24). Mr. Johnson further testified he was aware of an investigation into the propriety of the use of those monies from the federal government. (3/18/14 Tr. 25).

16. Records obtained from the Illinois Department of Employment Security shows Respondent carried an employee payroll ranging from 8 to 112 employees in 2009 through 2012. (PX9).

17. Woodlawn Organization was named as a Respondent by Petitioner Antonio Thomas in the Illinois Workers' Compensation case 12 WC 7955. In that case, the Commission issued a 4(d) certificate and found an employer-employee relationship existed on January 17, 2012 and Petitioner sustained accidental injuries on that date that arose out of and in the course of employment for which Respondent knowingly failed to provide workers' compensation insurance to Petitioner. (PX13).

18. The Commission takes judicial notice of several additional Illinois Workers' Compensation claims brought against Woodlawn Organization and/or Woodlawn Community Development including 00 WC 56309, 01 WC 50969, 03 WC 36585, 03 WC 18897, 03 WC 56459, 05 WC 22005, 05 WC 25452, 06 WC 10121, 09 WC 30604, 10 WC 14647, 12 WC 28613 and 13 WC 11785. (PX10).

Section 4 of the Act was codified July 1, 2005. We find that Respondents are subject to the Act as an employer. Section 4(a) of the Act requires all employers within the purview of the Act to provide workers' compensation insurance for the protection of their employees. The evidence shows Respondent had many employees, and, at times in question had over 100 employees. Further, Investigator Johnson observed several employees working at Respondent's 63rd Street location. A passenger van with Respondent's name was observed during the periods of non-compliance and it can be reasonably inferred it was operated in furtherance of Respondent's business, thereby bringing them within the automatic coverage provisions of Section 3 of the Act. Woodlawn Organization was a business operating in the State and required to have workers' compensation insurance, and the provisions of the Act apply automatically and without election in this case. The Commission finds, after review of the Record, that Respondent was in violation of Section 4(a) of the Act for a period of 253 days, encompassing the periods May 11, 2010 through December 1, 2010, and again from December 2, 2011 through January 18, 2012.

The next determination to be made by the Commission is whether Respondents willfully and knowingly violated the coverage requirements of the Act. Section 4(d) of the Act states in part:

> "Upon a finding by the Commission, after reasonable notice and hearing, of the knowing and willful failure or refusal of an employer to comply with any of the provisions of paragraph (a) of this Section or the failure or refusal of an employer, service or adjustment company, or an insurance carrier to comply with any order of the Illinois Workers' Compensation Commission pursuant to paragraph (c) of this Section disqualifying him or her to operate as a self insurer and requiring him or her to insure his or her liability, the Commission may assess a civil penalty of up to $500 per day for each day of such failure or refusal after the effective date of this amendatory Act of 1989. The minimum penalty under this Section shall be the sum of $10,000. Each day of such failure or refusal shall constitute a separate offense." 820 ILCS 305/4(d).

15IWCC0048

It is evident from the record that the Respondents were aware they were operating a business without workers' compensation insurance as required by the Act. Respondent has been named as employer in several workers' compensation claims before, during, and after the time periods in dispute. Respondent obtained workers' compensation insurance for its business in December 2010 and allowed the coverage to lapse by December 2011. Respondent did not seek to obtain self-insurer status or otherwise make provisions with the Commission to comply with Section 4 of the Act. Further, the Commission has previously found Woodlawn to have been in violation of Section 4 of the Act and issued a 4(d) certificate in claim 12 WC 7955. Respondents knew they were required to keep workers' compensation insurance and did so between periods of non-compliance. Petitioner has met its burden to prove Respondent had a knowing refusal or failure to obtain workers compensation insurance for the periods May 11, 2010 through December 1, 2010 and December 2, 2011 through January 18, 2012.

After considering the entire record and for the reasons set forth, the Commission finds that Respondent knowingly and willfully violated Section 4 of the Act for a 253 day period. Respondent shall pay the maximum non-compliance penalty under the Act in the amount of $500.00 per day and value of insurance premium saved for the period of non-compliance. Petitioner's witness, Investigator Johnson, testified that the last yearly worker's compensation insurance premium paid by Respondent was $90,968.00 and that figure was the amount saved in premium over a year by Respondent not carrying the required insurance. A yearly premium of $90,968.00 equates to $249.23 per day. Therefore, the amount of premium saved by Respondent's 253 days of non-compliance equals $63,055.19. The Commission awards a total fine of $189,555.19.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent Leon Jackson, Individually and President, Janice Sidney, Individually and Secretary, and The Woodlawn Organization, pay to the Illinois Workers' Compensation Commission the sum of $189,555.19 pursuant to Section 4 the Act and Section 7100.100 of the Rules.

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: JAN 20 2015

Daniel R. Donohoo

Charles J. DeVriendt

Ruth W. White

drd/adc
9/10/14
68

STATE OF ILLINOIS
) SS.
COUNTY OF SANGAMON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

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

vs.

NO: 12 INC 340

Michael C. Pinkston individually
And D/B/A Pinkston Concrete,
Respondent.

15IWCC0049

DECISION AND OPINION REGARDING INSURANCE COMPLIANCE

Petitioner, the Illinois Workers' Compensation Commission, Insurance Compliance Division, brings this action, by and through the Office of the Illinois Attorney General, against the above captioned Respondent, for failure to procure mandatory workers' compensation insurance and to obtain reimbursement from Respondent for compensation obligations paid by the Injured Workers' Benefit Fund in Claim No. 11 WC 46943 pursuant to Section 4 of the Illinois Workers' Compensation Act. Proper and timely notice was provided to the Respondent and a hearing was held before Commissioner Basurto in Springfield, Illinois on October 23, 2014.

Petitioner alleges that Respondent knowingly and willfully lacked workers' compensation insurance coverage intermittently for a minimum period of 264 days spanning from July 20, 2005 through January 11, 2012. Claim No. 11 WC 46943 was filed in regard to a work accident on November 17, 2011, during a period in which Respondent had no workers' compensation insurance. Claim No. 11 WC 46943 was ultimately found to be compensable. An award was granted in regard to the claim in the amount of $135,753.43 which was paid by the Illinois Injured Workers' Benefit Fund pursuant to Section 4(d) of the Act.

15IWCC0049

After consideration of the entire record, the Commission finds that Respondent knowingly and willfully violated Section 4(a) of the Act intermittently from July 20, 2005 through January 11, 2012 and shall pay a fine of $146,995.20 under Section 4(d) of the Act. In addition Respondent, Michael C. Pinkston individually and doing business as Pinkston Concrete , is to pay to the Illinois Workers' Compensation Commission the sum of $135,753.43 for reimbursement to the Illinois Injured Workers' Benefit Fund as provided under Section 4(d) of the Act.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

1. Joseph Stumph, a compliance investigator for Petitioner, testified at the October 23, 2014 Review Hearing as to his investigation.

2. Investigator Stumph testified he first became aware of Pinkston Concrete after he received a telephone call from Assistant Attorney General Rick Glisson about Claim No. 11 WC 46943. Mr. Glisson informed him that the case was set for May 4, 2012 before Arbitrator Neal. The case was ultimately heard by Arbitrator Zanotti on June 11, 2013. Investigator Stumph testified that he checked the National Council on Compensation Insurance (NCCI) database for the State of Illinois and found Pinkston Concrete had no insurance on November 17, 2011, which is the date of accident alleged for Claim No. 11 WC 46943. Petitioner's Exhibit #6, which is a copy of said search, was submitted into the record at the time of the hearing. Investigator Stumph testified that his search showed the insurance coverage for Pinkston Concrete was sporadic from July 20, 2005 through January 11, 2012 and that there was no insurance coverage on November 17, 2011, the date of the alleged accident for Claim No. 11 WC 46943. Investigator Stumph offered Petitioner's Exhibit #4 into evidence which is a copy of the July 15, 2013 Arbitration decision in which Arbitrator Zanotti issued a decision awarding 68 weeks of temporary total disability, $54,555.43 in medical expenses, a 30% person as a whole award along with $93,453.26 in additional compensation and attorneys' fees for a total award of $135,753.43, which was subsequently paid by the Illinois Injured Workers' Benefit Fund.

3. Investigator Stumph testified that although he made numerous contacts with Mr. Pinkston to negotiate a settlement of the insurance compliance matter, Mr. Pinkston made no attempt to contact him or to offer any attempt to settle this matter with the State.

4. The Commission admitted the following Petitioner's exhibits into the record:

PX1, Investigator Stumph's Non-Compliance Report for Pinkston Concrete.

PX2, an April 23, 2012 Notice of Non-Compliance sent to Mr. Pinkston Individually and d/b/a Pinkston Concrete.

PX3, a certified return receipt sent to Mr. or Mrs. Pinkston on December 30, 2013 through the United State's post office along with two Notices of the Noncompliance Hearings set for

15IWCC0049

February 27, 2014 and October 23, 2014. Mr. Stumph testified that the Insurance Compliance hearing was initially set for May 29, 2013. Subsequently, it was continued and reset to June 26, 2014. He personally sent Mr. Pinkston notice of the June 26, 2012 hearing. Investigator Stumph testified that Assistant Attorney General Rich Gisson, Mr. Pinkston and himself met in Springfield. Mr. Pinkston stated the he neither had money nor an attorney at that time. Mr. Pinkston's representations were brought to Commissioner Basurto's attention. The Commissioner advised him to hire an attorney and he continued the case to October 23, 2014.

PX4, Worker Compensation Computer Print-Outs pertaining to Claim No. 11 WC 46943 along with the July 15, 2013 Arbitration decision of Arbitrator Zanotti.

PX5, a report authored by Investigator Stumph which contained the dates of non-compliance along with mathematical computations regarding a daily penalty and daily savings for not possessing an insurance policy along with the Illinois Injured Workers Benefit payment for Claim No. 11 WC 46943. Together the two items total $282,748.63.

PX6, a Proof of Coverage Inquiry report generated by NCCI for Michael Pinkston individually and Michael Pinkston d/b/a Pinkston Concrete.

PX7, A letter from the Illinois Workers' Compensation Office of Self-Insurance indicating no Certificate of Self-Insurance was issued by the Commission to Michael Pinkston individually and to Michael Pinkston d/b/a Pinkston Concrete.

PX8, a computer report generated by the Illinois Department of Employment Security indicating a liability date of June 6, 1995, which is the date the business liability commenced and indicating the last time Michael Pinkston reported he had 12 employees for the 3rd month of the 3rd quarter of 2011.

PX9, an Illinois Department of Revenue report establishing that Pinkston Concrete was in effect and that on several occasions employees were listed for the business.

Respondent was personally put on notice by Investigator Stumph of the legal requirement to carry workers' compensation insurance on his business but as of the October 23, 2014 Hearing date he failed to offer any defense for the fact that he had been operating his business since February 12, 1997 with sporadic mandated workers' compensation insurance coverage and specifically no insurance coverage on November 17, 2011. The Commission finds Respondent willingly and knowingly violated Section 4 of the Illinois Workers' Compensation Act. The Commission orders Respondent to pay $282,748.63 under Section 4(d) of the Act.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent Michael Pinkston, Individually and doing business as Pinkston Concrete , pay to the Illinois Workers' Compensation Commission the sum of $146,995.20, pursuant to Section 4(d) of the Act.

15IWCC0049

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent Michael Pinkston Individually and doing business as Pinkston Concrete pay to the Illinois Workers' Compensation Commission the sum of $135,753.43 for reimbursement to the Illinois Injured Workers' Benefit Fund as provided under Section 4(d) of the Act.

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

DATED: JAN 2 1 2015

Mario Basurto

David L. Gore

Stephen Mathis

MB/jm

R: 10/23/14

43

STATE OF ILLINOIS)
) SS.
COUNTY OF KANE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Daniel Spayer,

Petitioner,

vs.

NO. 12 WC 35986

15IWCC0050

HH Gregg,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 17, 2013 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.

No bond is required for removal of this cause to the Circuit Court by Respondent.

15IWCC0050

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: JAN 21 2015

Stephen J. Mathis

Mario Basurto

David L. Gore

SJM/sj
o-1/15/15

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

SPAYER, DANIEL
Employee/Petitioner

Case# **12WC035986**

15IWCC0050

HH GREGG
Employer/Respondent

On 12/17/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.09% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

5019 LAW OFFICES STEVEN J SEIDMAN
RYAN A MARGULIS
500 LAKE COOK RD SUITE 350
DEERFIELD, IL 60015

2965 KEEFE CAMPBELL BIERY & ASSOC LLC
SEAN BROGAN
118 N CLINTON ST SUITE 300
CHICAGO, IL 60661

15IWCC0050

STATE OF ILLINOIS)
)SS.
COUNTY OF Kane)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Daniel Spayer
Employee/Petitioner

v.

HH Gregg
Employer/Respondent

Case # **12** WC **35986**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **George Andros**, Arbitrator of the Commission, in the city of **Geneva**, on **September 18, 2013** . After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **September 23, 2012**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$42,000.40**; the average weekly wage was **$807.70**.

On the date of accident, Petitioner was **29** years of age, ***single*** with **2** dependent children.

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

Respondent shall be given a credit of **$2,615.43** for TTD, $ for TPD, $ for maintenance, and $ for other benefits, for a total credit of $.

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

ORDER

PETITIONER'S CURRENT CONDITION OF ILL-BEING IS NOT CAUSALLY RELATED TO THE ACCIDENT OF SEPTEMBER 23, 2012. THEREFORE, PROSPECTIVE MEDICAL CARE INCLUDING BILATERAL KNEE ARTHROSCOPIES 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.

#01 George J. Andros
Signature of Arbitrator

Dec 13rd, 2013
Date

ICArbDec19(b)

DEC 17 2013

FINDINGS OF FACT AND CONCLUSIONS OF LAW 12 WC 35986

Daniel Spayer (hereinafter "Petitioner") began working for HH Gregg (hereinafter "Respondent") in April 2012. He testified he was cutting the seal off the back of a trailer to inspect its contents the afternoon of September 23, 2012. After he completed that task, he testified he jumped off of the dock approximately four feet to the ground and felt a "pop" in both knees. He worked the remainder of his shift and a full shift the next day before seeking medical attention. Petitioner confirmed he sustained a right knee injury prior to working for Respondent for which he underwent surgery.

Petitioner first sought medical attention from his primary care physician, Dr. Julia Bielat, on September 26, 2012. He stated his knees immediately swelled following the subject incident but the doctor found no swelling of either knee 48 hours later. His right knee had normal range of motion and normal alignment but the doctor noted an abnormal meniscus on exam. As for the left knee, he had a normal meniscus and the remainder of his exam was unremarkable other than some subjective complaints of tenderness. Bilateral knee pain was diagnosed. Physical therapy and/or MRIs were recommended as were light duty work restrictions of no bending, kneeling or jumping. Dr. Bielat referred Petitioner for orthopedic evaluation.

Dr. Aaron Bare of OAD Orthopaedics evaluated Petitioner on October 8, 2012. Negative menisci tests were noted on exam. X-rays of the bilateral knees were normal and bilateral knee pain was diagnosed. Physical therapy and light duty restrictions were recommended.Rather than initiating Dr. Bare's treatment plan, Petitioner sought a second opinion with Dr. David Zoellick on October 15, 2012. Dr. Zoellick was the orthopedist who performed Petitioner's prior right knee surgery. On exam, Petitioner complained of tenderness over the bilateral knees and pain with flexion. The doctor found mild effusion and noted positive Apley grind tests. Dr. Zoellick prescribed bilateral knee MRIs and recommended Petitioner refrain from all work activity. Bilateral knee MRIs were taken on October 25, 2012. The radiologist's impression was mild tendinosis of the distal quadriceps tendon of both legs along with mild bone contusion referable to the left knee only. The medial and lateral menisci of both knees were intact.

In November 2012, Petitioner travelled to Walt Disney World in Florida with his family. He testified he was there for 10 days during which time he visited and walked the theme park grounds. He also began working full time for Arc-Tronics, Inc. in November 2012. He testified he drives 80 miles round trip from his house in Aurora, IL to the Arc-Tronics facility in Elk Grove, IL. He further testified he was involved in a car accident in November 2012.

After starting his job with Arc-Tronics and returning from vacation, Petitioner followed-up with Dr. Zoellick on November 6, 2012. Following review of the MRI reports, not the actual films, the doctor diagnosed bilateral knee sprains along with a contusion and bone bruise of the left knee. Petitioner was given a knee brace and prescribed four weeks of physical therapy. Petitioner inquired whether surgery would be needed to which the doctor replied arthroscopy may be indicated if pain persisted. He was released to light duty with no lifting, kneeling, squatting or ladder climbing. Petitioner attended an initial physical therapy evaluation with Athletico on December 6, 2012. The report notes Petitioner was working full time with a different employer as a Material Controls Manager. He cancelled his second appointment on December 8, 2012 stating he was "going in a different direction."

Dr. Zoellick re-evaluated Petitioner on January 21, 2013. Petitioner complained of bilateral knee pain, left greater than right. He noted his pain used to be random but had become constant. He told Dr. Zoellick that he had started physical therapy but it was not helping. The Arbitrator notes Petitioner attended only a physical therapy evaluation with no subsequent therapy contrary to both his testimony and the information provided to Dr. Zoellick. Petitioner reported working 50-60 hours per week at Arc-Tronics. Bilateral knee injections were administered and Petitioner requested to proceed with arthroscopy.

On February 13, 2013, Petitioner presented to Dr. Ira Kornblatt for an section 12 evaluation at Respondent's request. Pettitioner reported going to DePaul University 20 hours/week while simultaneously working 40 hours/week for Arc-Tronics. His subjective complaints were noted as sharp, severe and constant pain to the bilateral anterior knees; however, his knee exams were normal including negative meniscal signs. Thus, the doctor noted Petitioner presented with exaggerated pain behavior. Dr. Kornblatt diagnosed resolved strains of the bilateral knees. He opined there were no objective findings to substantiate Petitioner's subjective complaints. Further, Petitioner was able to work full duty without restrictions. Last, no surgical intervention or further orthopedic treatment was necessary and Petitioner was at maximum medical improvement. The clinical tests performed by this Arbitrator's assessment correlated to the report of the MRI radiographics that no pathology existed to warrant even "diagnostic" surgery.

On April 8, 2013, Petitioner returned to Dr. Zoellick His complaints remained the same. He reported temporary improvement following previous injections. He requested further injections and to proceed with bilateral knee arthroscopies.

Conclusions of Law

In support of the Arbitrator's decision relating to Issue (F), whether Petitioner's current condition of ill-being is causally related to the subject incident, the Arbitrator concludes the following:

In analyzing whether Petitioner's condition of ill-being at the time of the hearing was causally related to the accident at bar, the Arbitrator relies upon the totality of the evidence. As such this includes Petitioner's treating medical records, the opinions of the Section 12 examiner & Petitioner's testimony.

After careful review of the totality of the evidence, the Arbitrator hereby adopts the exam findings of Dr. Bielat and Dr. Bare and further finds the opinions of Dr. Kornblatt to be most persuasive. The opinions of Dr. Bare of Orthopedic Associates of DuPage / Cadence and Dr. Ira Kornblatt certainly carry the greater weight in denying prospective surgeries in the case at bar.

Other than the claim of knee popping and reports of tenderness on exam, there is no evidence that any physical injury occurred as a result of the subject incident. Although the Petitioner used the word "popping" no MRI radiograph or examination of Aaron Bare M.D. or Ira Kornblatt M.D. found meniscal pathology to warrant surgery let alone "diagnostic" surgery.

Indeed, there was no hematoma, swelling or effusion noted on initial examination approximately 48 hours after the incident. Dr. Bielat's examination of Petitioner's knees was completely normal other than subjective complaints of tenderness. The doctor did note an abnormal meniscus of the right knee but wisely referred Petitioner to an orthopedic surgeon for a definitive evaluation. That doctor, Dr. Bare of Orthopedic Associates of DuPage, also found no outward signs of trauma and determined Petitioner had normal menisci upon physical examination. Finally, bilateral knee MRIs were negative for any meniscal or ligament injury.

The initial exam findings, or lack thereof, coupled with an absence of more urgent reatment and Petitioner having worked the remainder of his shift on September 23, 2012 and a full shift the next day, support the Arbitrator's finding that Petitioner did not sustain any appreciable acute injuries as a result of the subject incident.

Further, Petitioner's level of activity in the weeks and months following the subject incident is inconsistent with a person who sustains acute injury to his/her knees. First, Petitioner started a new job in November 2012 which requires him to drive 80 miles roundtrip, work 40-60 hours per week and be on his feet for the majority of the work day. Only a month after the incident, Petitioner was vacationing at Walt Disney World where he walked the theme park grounds for a span of 10 days. That is exactly why Dr. Kornblatt credibly opined Petitioner's complaints were due to fatigue and overuse and not any sequelae from the jumping incident.

As was the case with Dr. Bare, Dr. Kornblatt's clinically discovered no signs of meniscal injury on examination and the remainder of Petitioner's bilateral knee exam was entirely normal.

Therefore, the Arbitrator further adopts the findings of Dr. Kornblatt that his condition had stabilized at times referred to as maximum medical improvement.

The Arbitrator concludes as a matter of fact and as a conclusion of law in the case at bar that Petitioner's condition of ill-being at the time of hearing is not causally related to the accident of September 23, 2012.

In support of the Arbitrator's decision relating to Issue (K), whether Petitioner is entitled to any prospective medical care, the Arbitrator notes and concludes the following:

As the Arbitrator has found Petitioner's condition of ill-being is not causally related to the incident of September 23, 2012, the issue of prospective medical care is rendered moot. Irrespective of cause, however, the Arbitrator underscores the following regarding Petitioner's treatment to date and the reasonableness of the recommended bilateral arthroscopies: Rather than follow medical advise and enter a course of physical therapy program prescribed by both Dr. Bielat and Dr. Bare, Petitioner sought out Dr. Zoellick – the same doctor who operated on Petitioner's right knee in 2006. As it turned out Dr. Zoellick prescribed physical therapy as well.

Undermining credibility is that Petitioner falsely reported to Dr. Zoellick that therapy was not helping his bilateral knee symptoms. The evidence shows Petitioner completed only an initial physical therapy evaluation and cancelled his second appointment on December 8, 2012 stating he was "going in a different direction." There are no notations in the Athletico records of Petitioner complaining of inability to complete exercises or physical testing due to pain yet Petitioner testified that was the reason for his discontinuing therapy.

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

Shantrece Johnson,

Petitioner,

vs.

NO. 12 WC 33181 & 12 WC 36601

Seguin Services, Inc.,

15IWCC0051

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, temporary disability, permanent disability, medical expenses, 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 July 10, 2014 is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $18,900.00.

15IWCC0051

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: JAN 2 1 2015

SJM/sj
o-1/15/15
44

Stephen J. Mathis

Mario Basurto

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

JOHNSON, SHANTRECE
Employee/Petitioner

Case# **12WC033181**
12WC036601

SEGUIN SERVICES INC
Employer/Respondent

15IWCC0051

On 7/10/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.06% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0320 LANNON LANNON & BARR LTD
MICHAEL S ROLENC
180 N LASALLE ST SUITE 3050
CHICAGO, IL 60601

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

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

15 IWCC0051

- [ ] 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

Shantrece Johnson
Employee/Petitioner

v.

Seguin Services, Inc.
Employer/Respondent

Case # **12 WC 33181**

Consolidated case: **12 WC 36601**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Milton Black**, Arbitrator of the Commission, in the city of **Chicago**, on **February 24, 2014 and March 25, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **May 4, 2011 and March 29, 2012**, Respondent *was* operating under and subject to the provisions of the Act.

On these dates, an employee-employer relationship *did* exist between Petitioner and Respondent.

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

Petitioner's current condition of ill-being *is* causally related to the accident of **May 4, 2011**.

Petitioner's current condition of ill-being *is not* causally related to the accident of **March 29, 2012**.

In the year preceding the alleged injury of **May 4, 2011** and **March 29, 2012**, Petitioner earned **$23,400.00**; the average weekly wage was **$450.00**.

On **May 4, 2011**, Petitioner was **38** years of age, married with **1** dependent child.

On **March 29, 2012**, Petitioner was **39** years of age, married with **1** dependent child.

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

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

Respondent shall be given a credit of **$0** 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 **$8,238.08** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of **$300.00**/week for **17 5/7^{ths}** weeks, commencing **June 25, 2012** through **October 26, 2012**, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from **June 25, 2012** through **October 26, 2012**, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall pay reasonable and necessary medical services of **$8,238.08**, as provided in Section 8(a) of the Act.

Respondent shall be given a credit of **$8,238.08** for medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of **$270.00**/week for **50** weeks, because the injuries sustained caused the **10%** loss of the person as a whole, as provided in Section 8(d)2 of the Act. No benefits are awarded for the accident of March 29, 2012 because Petitioner's current condition of ill being is not causally related to that accident.

No benefits are awarded for the accident of **March 29, 2012** because Petitioner's current condition of ill being is not causally related to the accident of **March 29, 2012**.

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

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

Signature of Arbitrator

July 9, 2014
Date

JUL 10 2014

FACTS

Petitioner was employed by Respondent as a shared living companion. Petitioner claims that she sustained an initial accidental injury on May 4, 2011 and a second accidental injury on March 29, 2012. Petitioner testified in her case in chief and on rebuttal.

Petitioner testified that on May 4, 2011 when she was attempting to start a lawn mower, the pull cord got jammed, she tried to unjam the pull cord, the pull cord freed itself, and she pulled too hard injuring her right shoulder. Petitioner testified that eventually she did get the lawn mower started and that she started it. Petitioner testified that when she felt the pain, she dropped to her knees and was holding her shoulder for a little while. Petitioner testified that on May 4, 2011 she hired Wanda Brown, her cousin, to help her with the landscaping. Petitioner testified that Wanda Brown witnessed the accident and that Wanda Brown did the actual grass cutting once the lawn mower was started.

Petitioner testified that after the May 4, 2011 accident she continued her job duties for Respondent as a shared living companion.

Petitioner testified that she first received medical treatment on May 17 2011, when she was examined by Dr. Deborah Hinton, her primary care physician. Dr. Hinton's chart note of May 17, 2011 shows a chief complaint of pain to the right shoulder and back due to a fall about two weeks ago. The chart note then shows a history of present illness of pain to the right shoulder discomfort on and off for two weeks and denial of fall or recent trauma (PX1).

Petitioner testified that she went to the MacNeal Hospital emergency room on May 20, 2011, because she felt pain in her shoulder, the injury was more serious, the more she worked the longer she would have to rest, and she constantly had to rely on painkillers. The emergency room chart note states that Petitioner was complaining of an injury to her right shoulder of two weeks ago and that she felt pain after pulling repetitively on a lawn mower cord (PX2).

Petitioner testified that she gave verbal notice of her accident either on the emergency room visit date, May 20 2011, or the next day, May 21 2011. Petitioner testified that she left a voicemail message to her supervisor, Yolanda Gardner, or a voicemail message to different supervisor, Amber Grzda. Petitioner testified that she was familiar with Respondent's accident reporting procedures.

Petitioner testified that on March 29, 2012 she was attempting to restrain an unruly patient who was walking without his cane to prevent him from falling and that in so doing she fell, which caused pain to her left knee and her right shoulder.

Petitioner testified that she received medical treatment the same day at the MacNeal Hospital emergency room. The emergency room record gives a history of attempting to restrain a patient at work causing her to fall forward onto her left knee and causing pain to her left knee. Petitioner was treated for a knee contusion, was released, and was returned to work (PX2).

Petitioner called Wanda Brown as a witness. Wanda Brown testified that she witnessed the accident of May 17, 2011 and that she started the lawn mower after Petitioner was injured.

Petitioner has undergone right shoulder diagnostic testing, therapy, and arthroscopic surgery, and she has lost time from work. Respondent claims that there is no liability for medical benefits and temporary total disability benefits because an accident did not occur and because timely notice was not given.

Respondent called Yolanda Brown as a witness. Yolanda Brown testified that she did not receive a voicemail message reporting an accident, that her first notice of accident was on October 16, 2012, and that

Petitioner was considered an independent contractor. Yolanda Brown testified about Respondent's standard accident reporting procedures.

Respondent called Cheryl Miller as a witness. Cheryl Miller testified about Respondent's standard accident reporting procedures.

Respondent called Leonard Maniece as a witness. Leonard Maniece testified about Respondent's standard accident reporting procedures.

Respondent called Amber Grzda as a witness. Amber Grzda testified that they she did not receive a voicemail message from Petitioner reporting an accident. Amber Grzda testified about Respondent's standard accident reporting procedures.

The first written accident report documents were prepared on October 16, 2012 (RX2, RX3, RX4).

CONCLUSIONS OF LAW

12 WC 33181

ACCIDENT

The Arbitrator finds that Petitioner sustained an accident on May 4, 2011.

Petitioner testified that she injured herself as the result of pulling on a lawn more cord. Wanda Brown's testimony was essentially consistent, except for who eventually started the lawnmower. Dr. Hinton's records are internally inconsistent on history and therefore are unhelpful. The MacNeal Hospital emergency room records are corroborative and are consistent. Petitioner presented a *prima facie* case of accident, which was not rebutted.

NOTICE

The Arbitrator finds that Petitioner gave notice when she telephoned and left a voicemail message to a supervisor.

The Arbitrator is persuaded by Petitioner's testimony.

CAUSATION, MEDICAL, AND TEMPORARY TOTAL DISABILITY

The dispute on these issues is based upon liability which has been resolved in favor of Petitioner. Therefore the Arbitrator finds in favor of the Petitioner regarding causation and awards the claimed benefits.

NATURE AND EXTENT

Petitioner has proposed a permanency award of 10% loss of the person as a whole. Based upon the medical evidence and Petitioner's testimony, the Arbitrator agrees and so finds.

12 WC 36601

ACCIDENT AND CAUSATION

Petitioner's testimony and the corroborative emergency room records establish that a minor accident occurred on March 29, 2012. Petitioner was treated, released, and returned to work. She sustained a knee contusion. There is no medical evidence that the March 29, 2012 accident caused or aggravated Petitioner's shoulder condition.

Therefore, the Arbitrator finds that Petitioner's current condition of ill being is not causally related to the March 29, 2012 accident.

The remaining issues are moot.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Bruce Cram,

Petitioner,

vs.

NO. 11WC020823

15IWCC0052

Village of Schaumburg,

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 permanent disability/nature and extent and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 6, 2014 is hereby affirmed and adopted.

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

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

No bond is required for removal of this cause to the Circuit Court by Respondent.

15IWCC0052

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:
SJM/sj
o-1/15/15
44

Stephen J. Mathis

Mario Basurto

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CRAM, BRUCE
Employee/Petitioner

Case# **11WC020823**

15IWCC0052

VILLAGE OF SCHAUMBURG
Employer/Respondent

On 6/6/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% 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:

0787 MEYERS & FLOWERS LLC
RYAN P THERIAULT
3 N 2ND ST SUITE 300
ST CHARLES, IL 60174

0481 MACIOROWSKI SACKMANN & ULRICH
ROBERT B ULRICH
10 S RIVERSIDE PLZ SUITE 2290
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

BRUCE CRAM
Employee/Petitioner

v.

VILLAGE OF SCHAUMBURG
Employer/Respondent

Case # 11 WC 20823

15IWCC0052

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **DAVID KANE**, Arbitrator of the Commission, in the city of **CHICAGO**, on **05/20/14**. By stipulation, the parties agree:

On the date of accident, **02/21/09**, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $**83,200.00**, and the average weekly wage was $**1,600.00**.

At the time of injury, Petitioner was **39** years of age, ***single*** with **0** dependent children.

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

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

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

ORDER

Respondent shall pay Petitioner the sum of **$664.72**/week for a further period of **35.875** weeks, as provided in Section **8(e)** of the Act, because the injuries sustained caused **the complete and permanent loss of use of the right hand to the extent of 17.5% thereof.**.

Respondent shall pay Petitioner compensation that has accrued from **02/21/2009** through **05/20/2014**, and shall pay the remainder of the award, if any, in weekly payments.

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

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

David A. Kane
Signature of Arbitrator

June 6, 2014
Date

JUN 6 - 2014

FINDINGS OF FACT

The Petitioner is a 17 year veteran police officer with the Schaumburg Police Department who has served the department in a variety of positions. Currently, he is a Sergeant for the department but has served as a patrol and canine handler in the past. On February 21, 2009, the Petitioner suffered an undisputed right hand injury, including a right hand comminuted fracture, when he fell during a physical struggle with an eventual arrestee. The Petitioner is right hand dominant. The only issue in dispute is nature and extent of the Petitioner's injury.

The Petitioner sought immediate care at the employer's direction at Northwest Community Hospital Treatment Center. A CT scan was performed which demonstrated comminuted intra-articular fracturing at the base of the fifth metacarpal and associated carpometacarpal dislocation at the hamate articulation and the dorsal hamate. (PX 1).

On February 23, 2009, Petitioner was examined by Dr. William Vitello, who confirmed the CT scan impressions and diagnosis of a hand fracture. Dr. Vitello recommend operative intervention, including a closed reduction of the fracture with pinning. The operative intervention was performed under anesthesia on February 25, 2009. On March 2, 2009, the Petitioner followed up with Dr. Vitello. A splint was applied to the affected upper extremity and the Petitioner was ordered to wear it at all times. He was restricted from working and advised to not use his right hand. Physical therapy was also ordered for two times per week for four weeks. The Petitioner continued to experience pain and discomfort in the right hand. His work restrictions were kept the same as of March 20, 2009.

Due to continued pain and problems, the Petitioner underwent a second operative intervention to remove the implanted hardware that was causing the Petitioner discomfort. The retained hardware removal operation was performed on April 7, 2009. The procedure required two separate incisions and was performed under anesthesia. On April 13, 2009, the Petitioner was re-examined and ordered to undergo further therapy 2-3 times per week for 4 weeks. During this period, the Petitioner had light duty work restrictions including limited forceful gripping, limited lifting/pushing/pulling of 10 pounds. On May 29, 2009, the Petitioner was returned to work full duty and released from active care. (Px 2)

The Petitioner testified that although he can work full duty and engage in exercise, he still experiences pain in his right hand after physical activity, typing, or shooting a gun as is required for his employment as a Police Officer. He is less accurate when shooting a gun, although he can still qualify. He also does not lift the same amount of weight he did prior to the accident. He relies on over the counter pain medication to treat his symptoms several times per month. On a 1 to 10 pain scale (10 being the worst), the Petitioner's rated his persistent pain in the last 12 months as a 5 out of 10 at its worst and a 1 out of 10 as its best. The Petitioner has not pursued further medical treatment as he does not believe anything can be offered, other than medication, to treat his ongoing complaints.

CONCLUSIONS OF LAW

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

Petitioner suffered a comminuted right hand fracture, namely a

comminuted intra-articular fracturing at the base of the fifth metacarpal and associated carpometacarpal dislocation at the hamate articulation and the dorsal hamate. This undisputed accident and injury required two operative interventions. The surgeries were performed under anesthesia and involved the placement of and eventual removal of hardware which was placed to stabilize the fracture. In addition to surgery, the Petitioner underwent physical therapy and was restricted from full duty work for over three months. The Petitioner testified credibly at arbitration that he continues to have daily pain in the right hand with activities such as exercising, shooting his gun, or typing. The Petitioner's injuries are supported in the medical records admitted into evidence. (PX 1, Px 2). The Respondent offered no contrary medical opinion on the Petitioner's injuries, treatment, or current condition.

The Arbitrator finds, after considering the entire record, that Petitioner has suffered permanent partial disability to the extent of 17.5% of the right hand pursuant to Section 8(e) of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Mario Ferrici,

Petitioner,

vs.

NO. 14 WC 2434

Stanley Spring & Stamping Co.,

15IWCC0053

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19b having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical expenses, penalties and fees, 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 June 9, 2014 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.

No bond is required for removal of this cause to the Circuit Court by Respondent.

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

DATED: JAN 2 1 2015
SJM/sj
o-1/15/15

Stephen J. Mathis

David L. Gore

Mario Basurto

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

FERRICI, MARIO
Employee/Petitioner

Case# **14WC002434**

15IWCC0053

STANLEY SPRING & STAMPING CO
Employer/Respondent

On 6/9/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% 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:

0391 HEALY SCANOLON LAW FIRM
PATRICK C ANDERSON
111 W WASHINGTON ST SUITE 1425
CHICAGO, IL 60602

2837 LAW OFFICES JOSEPH A MARCINIAK
JAMES J MIRRO
TWO N LASALLE ST SUITE 2510
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

15IWCC0053

Case # 14 WC 2434

Mario Ferrici
Employee/Petitioner

v.

Stanley Spring & Stamping Co.
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **David Kane**, Arbitrator of the Commission, in the city of **Chicago**, on **May 20, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

15IWCC0053

FINDINGS

On the date of accident, **January 8, 2014**, Respondent *was* operating under and subject to the provisions of the Act.

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

On this date, Petitioner *did 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 $**49,946.52**; the average weekly wage was $**1,011.06**.

On the date of accident, Petitioner was **63** years of age, ***married*** with **0** dependent children.

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

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

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

ORDER

Because Petitioner did not sustain an accident that arose out of and in the course of employment, benefits are denied.

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

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

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

David A. Kane
Signature of Arbitrator

June 9, 2014
Date

ICArbDec19(b)

JUN 9 - 2014

Finding of Facts

Petitioner Mario Ferrici was employed by the Respondent as a maintenance technician on 1/8/14. Mr. Ferrici was terminated from his employment on 1/9/14. He went to the emergency room at Advocate Lutheran General on 1/17/14 with complaints of right shoulder and hip pain and stated he fell at work about one week ago. (Pet. Ex. 3). He then went to Orthopedic Surgery Specialists (OSS) on 1/22/14 and saw Dr. Jordan Goldstein. (Pet. Ex. 1). Mr. Ferrici gave an accident history to Dr. Goldstein of injuring his shoulder on 1/8/14 (Wednesday) when he slipped on the floor landing on his right side. The record notes this happened around 9am and that he went to pick up his wife at around 11am the same day. The notes state that the following day (Thursday) his boss notified him that he was being laid off, and that he notified his boss that he fell the previous day and was having right shoulder pain. It also states that on Friday he notified his supervisor of the injury. (Id). Dr. Goldstein assessed the petitioner with right shoulder pain and weakness and ordered an MRI. An MRI of the right shoulder was done on 2/3/14 and showed some interstitial tearing and a small partial tibial sided tear of the supraspinatus tendon, with large circumferential labral tear associated with pain labral cyst formation. Petitioner returned to OSS on 2/13/14, reviewed the MRI with his doctor, and received a subacromial injection. Physical therapy was recommended and he was prescribed an anti-inflammatory medication. (Id). He underwent an initial evaluation on 2/27/14 at Physical Therapy Institute of Illinois (PTI), and gave an accident history of working on heavy machinery at his job when he slipped and landed on his shoulder. Petitioner returned to Dr. Goldstein on 3/27/14 following 8 of 12 physical therapy sessions and improvement of the right shoulder was noted. Four more weeks of physical therapy were recommended, at which time he was to follow up with Dr. Goldstein. (Id).

Finding regarding whether Petitioner sustained accidental injuries that arose out of and in the course of employment

Petitioner testified that on 1/8/14 at around 9am, he was carrying some diaphragms into the compressor room when he slipped on oil and fell on his right shoulder, hip and leg. He stated that no one saw him fall, and that he did not report the injury to anyone at work in the two hours from the time he allegedly fell until he left work at 11am to take his wife to the hospital for a doctor appointment. While at the hospital with his wife he did not see any doctor for his alleged injury. Petitioner testified that he saw co-worker and supervisor Joe Canovas at the hospital, who was there for his own surgery, and claims he told him about his fall at work. Mr. Canovas testified explicitly, however, that the petitioner did not mention any injury at work to him, and that the conversation was solely personal in nature. Petitioner further testified that he was fired the next day by Reb Banas, and that he told Mr. Banas about the injury from the previous day after he had been fired. Mr. Banas, however, testified that the petitioner never told him anything about any injury, either before or after being fired. He also stated that the petitioner has had a litany of disciplinary problems with the company dating back to 2010, and he had been looking for a new worker to replace the petitioner as of the last disciplinary incident in September 2013. Mr. Banas testified that he was going to get petitioner's check and terminate him on the alleged date of accident, but petitioner had already taken his check early again and had left for the day. The petitioner was fired by Mr. Banas the following day for taking his checks early, refusing to do work, and other performance issues. The petitioner's other manager, Thomas Lusinski, also testified that neither the petitioner nor anyone else ever reported or mentioned an injury to him, and that the first he had heard of any alleged accident was after petitioner had filed the Application.

In summary, petitioner alleges an un-witnessed slip and fall accident the day before he was fired for taking his check early and for other assorted issues with his employer. Petitioner's co-workers and supervisors testified that they were not aware of any alleged accident until they received the Application from petitioner's attorney, and they also testified that the Petitioner never reported any accidental injury to them as he claimed. Petitioner also did not seek any medical treatment until over a week after he was fired. The arbitrator finds the testimony of Reb Banas, Joe Canovas, and Thomas Lusinski to be more credible than that of the petitioner. The petitioner has failed to meet his burden of proving that he sustained an accidental injury at work. The arbitrator finds that petitioner did not sustain an accidental injury that arose out of and in the course of employment.

Finding regarding causal connection, TTD benefits, and medical expenses

Because Petitioner did not sustain an accidental injury that arose out of and in the course of employment, the arbitrator finds that Petitioner's current condition of ill-being is not causally connected to the alleged injury.

Due to the Arbitrator's findings on the issues of accident and causal relationship, all other issues are rendered moot.

Therefore, compensation is hereby denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Denise E. Lenoue,

Petitioner,

vs.

NO. 08WC055403

15IWCC0054

Resurrection Medical Center,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of temporary disability, permanent disability, causal connection, medical expenses, penalties and fees and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 27, 2014 is hereby affirmed and adopted.

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

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

No bond is required for removal of this cause to the Circuit Court by Respondent.

15IWCC0054

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: JAN 2 1 2015
SJM/sj
o-1/15/15
44

Stephen J. Mathis

David L. Gore

Mario Basurto

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

LENOUE, DENISE E
Employee/Petitioner

Case# **08WC055403**

RESURRECTION MEDICAL CENTER
Employer/Respondent

15IWCC0054

On 1/27/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.06% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1129 LAW OFFICES JORDAN B RIFIS PC
1034 PLEASANT ST
1ST FLOOR
OAK PARK, IL 60302

2965 KEEFE CAMPBELL BIERY & ASSOC LLC
ARIK D HETUE
118 N CLINTON ST SUITE 300
CHICAGO, IL 60661

15IWCC0054

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

Denise E. Lenoue
Employee/Petitioner

v.

Resurrection Medical Center
Employer/Respondent

Case # 08 WC 55403

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 **Jeffrey Huebsch**, Arbitrator of the Commission, in the city of **Chicago**, on **November 21, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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 _____

15IWCC0054

FINDINGS

On **May 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 not* causally related to the accident.

In the year preceding the injury, Petitioner earned **$25,306.84**; the average weekly wage was **$486.67**.

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

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

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

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

Respondent is entitled to a credit of **$5,061.37** under Section 8(j) of the Act for non-occupational disability benefits paid and to a credit of $36,551.49 for medical benefits paid, pursuant to the agreement of the Parties.

ORDER

Denial of benefits

Claim for compensation denied. Petitioner failed to prove a causal connection between the accidental injuries of May 30, 2008 and her current condition of ill-being with respect to her left and right knees.

No benefits are awarded.

Penalties

Respondent shall pay to Petitioner penalties of **$0**, as provided in Section 16 of the Act; **$0**, as provided in Section 19(k) of the Act; and **$0**, 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

January 27, 2014
Date

JAN 27 2014

FINDINGS OF FACT

The Parties stipulated that Petitioner sustained accidental injuries, arising out of and in the course of her employment by Respondent on May 30, 2008.

Petitioner was employed by Respondent as a housekeeper. Her date of hire was October 9, 1995. Her job duties included mopping, sweeping, cleaning baseboards on her hands and knees, cleaning and disposing trash.

Petitioner had treatment by Dr. Thomas Karnezis for a trigger finger condition in her hands from 2004 to 2006 and an injured left knee at work in 2006. Dr. Karnezis provided Respondent's claims administrator with reports regarding this treatment. (Pet Ex 1, Ex 2) Regarding the 2006 left knee injury, Petitioner testified that she bruised her left knee really bad when she tripped over a vacuum cleaner at work on May 23, 2006. Petitioner was taken off work on May 23, 2006, with a release to light duty on June 7 and to full duty effective June 14, 2006. Dr. Karnezis considered the possibility of meniscal pathology in his chart note of June 21, 2006. Petitioner testified that the left knee treatment continued through July 19, 2006. She said that she had no treatment for her knees and had suffered no injuries to her knees from July of 2006 through May of 2008.

Petitioner testified that on May 30, 2008, she was mopping the president and CEO's floor and she slipped on the wet floor and fell. She said that she twisted both knees and both knees struck the floor. Petitioner testified that she sought treatment at Respondent's Emergency Room.

Petitioner testified that she told the ER personnel that she slipped on the wet floor while mopping, twisted both knees and struck both knees on the floor. Petitioner testified that she told the ER personnel that both knees hurt, but the ER personnel focused everything on the left knee because it looked the worst and was swollen. The records from Resurrection Hospital for the ER visit do not contain any reference to right knee pain or injury. The history was that the patient fell while mopping and had left knee pain. There was no swelling or bruising of the left knee noted. Mild tenderness to palpation above the patella was noted. Petitioner was able to walk with a steady gate. Only the left knee was x-rayed. She was released with instructions to follow up as needed and to take Motrin/Tylenol for pain. No work restrictions were given. The diagnosis was left knee strain. (Pet Ex 2)

The next medical treatment was almost five months later, on October 22, 2008, when Petitioner saw Dr. Karnezis for bilateral knee pain complaints. Petitioner testified that she gave Dr. Karnezis the history of slipped on the wet floor, twisted both knees and fell on the hard floor. This history is not contained in Dr. Karnezis' records and was not supported by his testimony. (Pet Ex 1, Ex 2) The chart note for this visit says that the patient suffered a knee strain at work and for the past 5 months has been in pain; "now the contralateral knee has been been bothersome." Dr. Karnezis' testimony confirmed the chart note. Petitioner was given splints and medication. She was told to follow up and to continue to work full duty. (Pet Ex 1 at pp18-19)

Petitioner followed up with Dr. Karnezis on December 29, 2008. MRI studies of the left and right knee were reviewed. Both studies showed meniscal pathology, with the right knee study showing patellofemoral cartilage thinning and the left knee study showing a trochlear cartilage injury. The left knee study showed a lateral meniscus tear, whereas the primary complaints and findings regarding the left knee in 2006 concerned the medial side of the knee. Dr. Karnezis recommended that Petitioner undergo surgery on both of her knees. First the left, then the right.

Petitioner continued to work full duty for Respondent, so that she could build up sick time for when she would be off work after the surgery. While she was working full duty, she slipped and fell on ice in Respondents' parking lot in January of 2009 and injured her left knee.

Dr. Karnezis performed surgery on Petitioner's left knee on May 12, 2009. After the surgery, Petitioner underwent therapy and a course of injections and was released to return to work at full duty on July 12, 2009. Petitioner underwent right knee surgery on September 7, 2010. Petitioner again underwent a course of physical therapy and injections and returned to work at regular duty on December 1, 2010. During the time that Petitioner was off work after the surgeries, she received sick pay.

Petitioner testified that after she returned to work in December of 2010, her knees started to bother her and she decided to resign. She has not worked anywhere since resigning. She has not seen Dr. Karnezis since December of 2010.

Petitioner testified that she has pain in her knees. She has difficulty going up and down stairs and difficulty with bending.

Petitioner was seen by Dr. Raab at the request of her employer on October 1, 2012. Petitioner said that the examination took about 15 minutes.

Dr. Karnezis testified on behalf of Petitioner and opined that there was a causal connection between the accidental injuries of May 30, 2008 and the condition of ill-being in Petitioner's left and right knees.

Dr. Raab testified on behalf of Respondent and opined that there was no causal connection between the accidental injuries of May 30, 2008 and the condition of ill-being in Petitioner's left and right knees, specifically with respect to the treatment that began 5 months after the accident date.

CONCLUSIONS OF LAW

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

The Arbitrator finds that Petitioner failed to prove that her current condition of ill-being regarding her left and right knees is causally related to the injury.

Petitioner did sustain accidental injuries that arose out of and in the course of her employment by Respondent on May 30, 2008. The injuries that Petitioner sustained on May 30, 2008 were inconsequential and did not lead to the surgeries and current disability related to Petitioner's knees.

The records of Resurrection Hospital show that on May 30, 2008 Petitioner was treated for a left knee contusion sustained when she fell on water while mopping at work. There is a history of twisting the left knee noted. There is no mention of any injury to the right knee contained in the records. There was a work up for a left knee sprain and the physical findings and x-rays of the left knee were largely benign. Petitioner said that she told the ER personnel that she slipped on a wet floor, twisted both knees and hit the floor hard with both knees. This

testimony is not credible. It is presumed that a declaration to a treating physician as to one's physical condition and the cause thereof is true because the patient will not falsify such statements to the one from whom he expects to get medical aid. Shell Oil Co. v. Industrial Commission, 2 Ill.2d, 590, 602 (1954) Here, the history was of trauma to the left knee only. If Petitioner had given the history of twisting and falling hard on both knees, there would have been a work-up for the right knee at the ER. There is no mention of anything regarding the right knee in the records from Resurrection.

Petitioner was to follow up as needed, but she did not seek additional treatment until 5 months after the accident. Petitioner was working full time as a housekeeper, at a hospital, during this time. Her testimony regarding continued problems with her knees related to the accident in question is not believable because she did not seek follow up care for her alleged injuries within a reasonable time. She was actually at the hospital during this time and it is reasonable to assume that she understood how workers' compensation medical treatment is provided because she had follow up care with Dr. Karnezis regarding the prior hand and left knee injuries.

While Petitioner testified that she gave Dr. Karnezis the same history of slipping on the wet floor, twisting both knees and falling on the hard floor, this testimony is not supported by Dr. Karnezis' testimony or his records. Dr. Karnezis' testimony and records reveal a history of a knee strain at work 5 months before, with continued pain and now the contralateral knee is hurting. The Arbitrator finds that Petitioner's testimony regarding the mechanism of the injuries sustained on May 30, 2008 and the histories given to the ER and Dr. Karnezis is not believable.

Dr. Karnezis' causal connection opinion is not consistent with Petitioner's testimony as to injuries sustained to both knees at the time of the accident and is not persuasive in this case.

Dr. Raab's opinion that there is no causal connection between the fall of May 30, 2008 and the treatment for both knees that began 5 months later is persuasive, credible and most comports with the evidence adduced. The Arbitrator finds that there is no causal connection between the accidental injuries of May 30, 2008 and petitioner's current condition of ill being with respect to both of her knees.

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 claimed medical expenses are for services rendered after the emergency room treatment on the date of accident.

As the Arbitrator has found that Petitioner failed to prove a causal connection between the accidental injuries of May 30, 2008 and her condition of ill being regarding her left and right knees, the Arbitrator needs not decide this issue.

WITH RESPECT TO ISSUE (K), WHAT AMOUNT OF COMPENSATION IS DUE FOR TEMPORARY TOTAL DISABILITY, TEMPORARY PARTIAL DISABILITY AND/OR MAINTENANCE, THE ARBITRATOR FINDS AS FOLLOWS:

The claimed TTD is for the time periods after the knee surgeries performed by Dr Karnezis in 2009 and 2010.

As The Arbitrator has found that Petitioner failed to prove a causal connection between the accidental injuries of May 30, 2008 and her condition of ill-being with respect to her left and right knees, the Arbitrator needs not decide this issue.

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

As the Arbitrator finds that Petitioner has failed to prove a causal connection between the accidental injuries of May 30, 2008 and Petitioner's current condition of ill-being with respect to her left and right knees, the Arbitrator needs not decide this issue.

WITH RESPECT TO ISSUE (M), SHOULD PENALTIES BE IMPOSED UPON THE RESPONDENT, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner made a claim for Penalties and Fees at the time of trial. She did not file a written penalty petition. Due process obviously requires that Respondent be given notice of a claim for Penalties prior to the commencement of the hearing.

Further, the Arbitrator finds that Respondent's disputes in this case were in good faith and not for any improper purpose.

Accordingly, the claim for Penalties and Fees is denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Eddie Morales,

Petitioner,

vs.

NO. 10 WC 26564

Bubbles Inc.,

Respondent.

15IWCC0055

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 permanent disability, temporary disability, causal connection, 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 4, 2014 is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $32,100.00.

15IWCC0055

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: JAN 2 1 2015

SJM/sj
o-1/15/15
44

Stephen J. Mathis

David L. Gore

Mario Basurto

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MORALES, EDDIE
Employee/Petitioner

Case# **10WC026564**

15IWCC0055

BUBBLES INC
Employer/Respondent

On 6/4/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% 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:

2356 DONALD W FOHRMAN & ASSOC
ADAM J SCHOLL
101 W GRAND AVE SUITE 500
CHICAGO, IL 60610

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

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

15IWCC0055

☐ 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

Eddie Morales Case # **10WC 26564**

Employee/Petitioner

v. Consolidated cases:

Bubbles, 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 **Arbitrator Ketki Steffen,** Arbitrator of the Commission, in the city of **Chicago,** on **3/4/14 & 3/6/14.** After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On 5/22/2010, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the seven weeks preceding the injury, Petitioner earned $5,558.80; the average weekly wage was $794.11.

On the date of accident, Petitioner was 49 years of age, married with 3 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 $ 68,509.73 for TTD, $ for TPD, $ for maintenance, and $ for other benefits, for a total credit of $ 68,509.73.

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

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of $476.47 for 125 weeks, because the back injuries caused the 25% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $476.47/week for 0 weeks, because the injuries sustained caused the 0% loss of use of the right leg, as provided in Section 8(e) of the Act.

Respondent shall be given a credit of $ 68,509.73 for temporary total disability benefits that have been paid.

Respondent shall pay Petitioner temporary total disability benefits of $529.41/week for 77 3/7 weeks, commencing 5/23/10 through 11/15/11 at a rate of $529.41, for a total of $40,991.28. Parties have stipulated that Respondent is entitled to a credit of $68,509.73. Respondent shall receive credit for overpayment of 27,518.45.

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

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

Kelli Steffen
Signature of Arbitrator

6/4/14
Date

JUN 4 - 2014

ICArbDec p. 2

PROCEDURAL HISTORY

This matter was presented for a hearing on the merits before Arbitrator Ketki Steffen on March 4, 2014 and March 6, 2014. Both parties were represented by counsel and have entered into several stipulations that are contained as Arbitrator's Exhibit No. 1 ("AX1") for the trial record. The disputed issues are whether the Petitioner's current condition is causally related to the injury; what are the Petitioner's earnings, whether TTD benefits are owed to the Petitioner and if so, how much; what the nature and extent of the injury is and whether the Respondent is entitled to any credit. The case relates to an accident date of May 22, 2010; a date which predates the September, 2011 AMA guidelines amendment to the Act.

FACTUAL HISTORY

Eddie Morales ("Petitioner") was 49 year old when he worked for Bubbles Inc. ("Respondent") as a window washer. He was hired on April 5, 2010. His responsibilities included caring ladders and buckets add he was required to stand, bend, stoop, and kneel to perform his job functions.

On May 22, 2010, he he was working by himself in Evanston at the residence cleaning windows. The owner asked him to clean a high ceiling fan. After receiving permission from his employer, Petitioner proceed to do so. While cleaning the ceiling fan, he fell off a 25 foot ladder. Petitioner testified that the ceiling fan was located in a bedroom that had thirty foot ceilings. Petitioner and the homeowner carried into the house an extension ladder and stood up the ladder against a beam that ran across the ceiling. Petitioner was on top of the ladder when the ladder fell. Petitioner testified that he held onto the ceiling beam for a few moments and then fell to the ground. Petitioner initially landed on his feet and then fell backwards onto the ladder that was on the

ground. The entire incident was witnessed by the homeowner. Petitioner stated that he was on the ground for about twenty minutes. At the time, he felt pain in his lower back and a burning pain into his legs. Petitioner gathered himself and his equipment with the help of the homeowner and he drove himself home. He felt pain in the bottom of both feet, and in his back.

On May 25, 2010, Petitioner went to St. Margaret Mercy Hospital for treatment of an unrelated burn injury. He also informed them about his work accident and complained of the pain in the feet and back. The Hospital released him with work restrictions that the provided to his employer.

On July 6, 2010 Petitioner was seen by Dr. Veldman who advised him to continue therapy, light duty and get an MRI. On a follow-up appointment, Dr. Veldman reviewed the MRI as diagnosed Petitioner with a back sprain and a left knee sprain. An MRI of the lower back was ordered.

On August 9, 2010, Petitioner saw by Dr. Kathleen Weber at Midwest Orthopedics at Rush at the request of the Respondent. (RX1). Petitioner reported his accident and injuries and stated that physical therapy did not improve his condition. He complained on ongoing bilateral calf pain, periodic left knee pain, and central lower back pain. (RX1 at 2). Dr. Weber reviewed the lumbar x-ray from St. Margaret Mercy and found degenerative changes. (RX1 at 3). She reviewed the left knee MRI and found degenerative changes, but felt it was otherwise unremarkable. (RX1 at 3). Dr. Weber diagnosed lower back pain with bilateral lower extremity radiculopathy. (RX1 at 3). She recommended a lumbar MRI, a Medrol Dose-pak, and recommended the Petitioner remain off work until the MRI was performed. (RX1 at 3). She recommended

two weeks of physical therapy for the knee, after which Petitioner would reach MMI for that injury. (RX1 at 3). Dr. Weber diagnosed "left knee complaints." (RX1 at 3).

On September 2, 2010 Petitioner returned to Advocate Health and reported burning pain from both knees down to the bottom of his feet and pain moving higher up his back. A Medrol/Dosepack was ordered.

On September 15, 2010 Petitioner underwent a MRI of his lumbar spine that revealed multi-level degenerative disc disease. (PX2 at 29-30). A follow up appointment with Dr. Veldman led to a referral to an orthopedic, Dr. Michael Chang of Midwest Spine Care.

Dr. Chang is a board certified orthopedic physician whose practice consists of 95% spine care. Petitioner first saw Dr. Chang on October 12, 2010. (PX3 at 22). Dr. Chang diagnosed chronic lower back pain, an L5-S1 disc hernia ion, an annular tear, aggravation of moderate disc degeneration, but no obvious radiculopathy. (PX3 at 22). Dr. Chang recommended conservative treatment in the form of physical therapy and injections, recommended Petitioner remain off work, and indicated he did not anticipate surgery would be required. (PX3 at 22).

Petitioner was seen by Dr. Angelopolous on October 26, 2010 for evaluation for injections. (PX2 at 3,4). Petitioner began physical therapy at Acceleration Rehab that day. (PX3 at 115). He had his first steroid injection on November 2, 2010. (PX2 at 7).

On November 9, 2010, Petitioner returned to Dr. Chang and reported no relief from the injection. (PX3 at 24). Dr. Chang recommended a discogram. (PX3 at 24). This was performed on November 22, 2010 and found no pain at L2-3, L3-4, and L4-5, but pain at 8/10 at L5-S1. (PX2 at 14-15). A lumbar CT scan that day confirmed a central disc protrusion at L5-S1. (PX2 at 24). When Petitioner returned to Dr. Chang on

December 14, 2010, he reviewed the diagnostics and recommended surgery at L5-S1. (PX3 at 25). Dr. Chang performed an L5-S1 laminectomy, partial facetectomy, discectomy, and fusion on January 19, 2011. (PX3 at 41).

Per-operatively, Dr. Chang diagnosed L5-S1 disc degeneration, foraminla stenosis and disk herniation. Surgery consisted of L5-S1 laminectomy, partial facetectomy, forminotomy, disectomey, internal fusion with atograft. Postoperatively, Petitioner developed postoperative tachycardia which extended his hospital stay. Petitioner was seen for a surgery follow-up appointment and had some issues with fever, possible infection, fluid collection and pain. Petitioner was treated for the same with antibiotics and aspiration.

Dr. Chang also saw Petitioner on February 22, 2011 and indicated a recent MRI revealed normal post-operative findings. (PX3 at 26). Petitioner returned to Dr. Chang on March 10, 2011, who indicated an x-ray that day showed a well healing fusion. (PX3 at 28). Petitioner began post-operative physical therapy at Accelerated Rehabilitation on March 17 2011. (PX3 at 117). Petitioner told Dr. Chang on May 31, 2011 that physical therapy was not helping ongoing pain complaints. (PX3 at 11).

On June 2, 2011, Petitioner underwent bilateral foot x-rays that revealed no abnormalities, and a lumbar MRI that revealed no moderate or severe stenosis, and no neuroforaminal narrowing. (PX3 at 36-37).

Dr. Chang examined Petitioner on June 7, 2011 and noted continued lower back and right leg pain. (PX3 at 12). He felt Petitioner may have a rheumatological condition that was aggravated by the fusion, and referred him to a rheumatologist, and recommended an MRI of the pelvis to look for signs of sacroilitis. (PX3 at 12). Petitioner was seen by rheumatologist Dr. Malkani on June 17, 2011, who

recommended an MRI to determine if the petitioner had sacroilitis. (PX3 at 60). A pelvic MRI was performed on June 29, 2011 that revealed no evidence of sacroilitis. (PX3 at 38). Petitioner returned to Dr. Chang on July 12, 2011 and continued to complain of continued pain. (PX3 at 13). Dr. Chang recommended an EMG of the lower extremities and an SI injection. (PX3 at 13). The EMG was performed on July 27, 201 and revealed borderline slow nerve conduction on the right posterior tibial nerve. (PX2 at 27). Dr. Angelopoulos saw Petitioner again on August 2, 2011 and noted complaints of right buttock pain despite the sacroiliac injection. (PX2 at 17). A further injection was performed that day. (PX2 at 17).

On June 17, 2011 Petitioner was seen by Dr. Manjani Malkani, a rheumatologist per a referral by Dr. Chang. Dr. Chang's notes show that there were no underlying causes for inflammation or joint disorder per the specialty. Dr. Chang opined that Petitioner's overall lower back pain, right hip and SI pain were the result of his work injury. He recommended EMG testing and a trial SI injection to the right side. Dr. Angelopoulus performed the sacroiliac injection and Petitioner reported relief from the same.

A July 27, 2011 EMG revealed radiculopathic changes at L5-S1 on the right side.

When Petitioner returned to Dr. Chang on August 11, 2011, he was given permanent restrictions. (PX3 at 14). Dr. Chang noted Petitioner could only tolerate sitting and standing for a few minutes at a time. (PX3 at 14). Dr. Chang stated Petitioner was completely and permanently disabled, should look into disability applications and medical retirement. (PX3 at 14). He did not think that an FCE was appropriate. During the deposition testimony, Dr. Chang stated that Petitioner had

chronic lower back pain and that in his opinion; Petitioner had a failed back syndrome. He recommended long pain management.

On September 26, 2011, Petitioner was seen again by Dr. Weber. Dr. Weber opined that Petitioner's diagnosis was causally related to his initial injury and related injury treatment. Dr. Weber suggested a CT scan to verify that the fusion was solid and also felt that an FCE or work conditioning was premature.

On September 30, 2011 Petitioner was seen by Dr. Asokumar Buvanendran . (PX3 at 80). Dr. Buvandendran authored a letter thanking Dr. Chang for the referral. (PX3 at 80). Dr. Buvanendran recommended physical therapy, an FCE, and another injection. (PX3 at 83). Petitioner returned to Dr. Buvandendran on October 26, 2011 for a second ESI. (PX7 at 3 of 23).

During an October 10, 2011 appointment, Dr. Chang recommended an epidural injection but was against work conditioning program. At a November 15, 2011 appointment, Petitioner reported that the injections did not help. (PX3 at 16). Dr. Chang therefore recommended an FCE to determine the petitioner's permanent restrictions, after which he would consider him to have reached MMI. (PX3 at 16). He advised the petitioner should remain off work until he returned with the FCE results. (PX3 at 16).

The FCE was scheduled for December 8, 2011. Petitioner did not attend at that time. Petitioner testified he went to a wedding in New Jersey at that time. He testified at trial that while in New Jersey he slipped down 12 stairs at his cousin's house and broke his left ankle. He testified he went to the ER in New Jersey and had a surgery. He testified the fall did not affect his back. He testified he could not remember the hospital he treated at, or the town in which the accident occurred. (T. 59).

A January 9, 2012 medical records from Stroger Hospital in Chicago indicates he suffered a left pilon fracture in New Jersey three weeks prior. (RX4 at 41). Petitioner reported to the staff at Stroger that this was suffered in a hit and run motor vehicle accident in New Jersey. (RX4 at 41). Petitioner received external fixation to his left leg in New Jersey, and presented to Stroger with that hardware intact. (RX4 at 41). An x-ray and CT scan performed that day showed a significant depressed articular segment, anteromedial and medial malleolar, with a separate fracture fragment anterolateral. (RX4 at 41). Petitioner was advised if he did not undergo surgery, he was at risk for developing arthritic change and possible deformity with collapse of the depressed segment. (RX4 at 41). The Stroger medical notes and history contain no mention of Petitioner complain of any back pain or mention any previous injury. (RX4 at 1-55). On January 13, 2012, Petitioner returned to Stroger Hospital and underwent the surgical removal of an external fixator and open reduction and internal fixation of a left pilon fracture, as performed by Dr. Jorge Prieto. (RX4 at 22).

Petitioner testified he told Stroger Hospital that he was injured in a hit and run motor vehicle accident because he wanted to avoid paying the hospital bills. (T. 58).

On January 19, 2012, Petitioner returned to Accelerated for an FCE with a November 15, 2011 prescription from Dr. Chang. (RX3). As he was on crutches, he was unable to perform the FCE and was advised to obtain clearance from his ankle doctor before getting an FCE. (RX3).

Petitioner returned to Stroger on February 1, 2012, March 14, 2012, and April 11, 2012. (RX4 at 10, 12, 14). There are no notes from those days. He testified he went to the doctor a few times for his ankle, but stopped going because it felt fine. (T. 62).

Dr. Chang examined Petitioner on May 22, 2012 and stated he had reached MMI. (PX3 at 17). He also noted Petitioner "still has not made full recovery from the ankle surgery." (PX3 at 17). He felt that Petioner could not return to gainful employment or even light duty. Dr. Chang felt that the FCE was not appropriate and that the Petitioner could not even perform light duty in a safe manner. He recommended pain management.

On October 29, 2012 Petitioner underwent a third IME with Dr. Weber. Dr. Weber performed a record review and conducted a medical examination. Dr. Weber opined that no further medical treatment was necessary other then anti-inflammatory medications and that Petitioner should under a FCE and maybe a work conditioning program.

On November 27, 2012 Petitioner returned to Dr. Chang who reviewed Dr. Weber's report and agreed with the FCE recommendation. Dr. Chang also recommended tapering off the narcotic medications.

Petitioner underwent an FCE at Accelerated Rehabilitation Centers on December 4, 2012. (PX5 at 1). Petitioner reported he was only able to lift 15 pounds before he self-terminated the test due to pain. (PX5 at 4). Petitioner self-terminated a bilateral hand lift of 8 pounds, due to reported low back pain. (PX5 at 4). Petitioner was only able to carry bilaterally 8 pounds while walking 25 feet before he self terminated due to pain. (PX5 at 4). The FCE concluded the overall results did not represent a true and accurate representation of Petitioner's overall physical capabilities and tolerances at the time. (PX5 at 1-2). Therefore, the results of the evaluation were only a minimal level of function. (PX5 at 2). A physical demand level could not be determined due to Petitioner's inconsistent reliability of pain and inconsistent effort. (PX5 at 2). The FCE

found Petitioner presented with significant observational and evidence based contradictions resulting in consistency of effort discrepancies and self-limiting behaviors. (PX5 at 2). In addition, Petitioner demonstrated 93.8% inconsistent pain ratings. (PX5 at 2). As a result, the report found Petitioner was capable of greater functional abilities than that demonstrated. (PX5 at 2). Petitioner testified his TTD was terminated because he failed the FCE.

On January 8, 2013, Petitioner returned to Dr. Chang with his FCE report. Dr. Chang disagreed with the FCE findings. During deposition testimony, Dr. Chang stated that the FCE's findings are subjective and that an evaluator meeting Petitioner for the first time did not have the benefits of prior knowledge. Dr. Chang testified that Petitioner cannot put in a meaningful, gainful work day due to this accident. Dr. Chang testified that Petitioner should not work with any heavy equipment, vibratory tools or moving tools. He also would limit him to ground work only with no bending, twisting or squatting.

Surveillance Tapes

Two Surveillance videos are introduced into evidence accompanied by the accompanying testimony of Respondent's witness Alan Brooks and Richard Simpson. Al Brooks testified he is employed as an investigator with Bonnamy and Associates. As part of his job duties, he performs surveillance of workers' compensation claimants. He records on video these claimants. He investigated the petitioner and performed surveillance on September 6, 2012, and November 7, 2013. (RX9, RX10). He took a video of his observations. He made a CD containing that surveillance that was entered as Respondent's Exhibits 9 and 10. He also testified as to what he saw.

Rick Sampson testified he is employed as an investigator with Bonnamy and Associates. As part of his job duties, he performs surveillance of workers' compensation claimants. He records on video these claimants. He investigated the petitioner and performed surveillance on September 11, 2012. He took a video of his observations. He made a CD containing that surveillance that was entered as Respondent's Exhibit 9. He testified as to what he saw.

Respondent's Exhibit 9 "RX9" includes the surveillance taken of Petitioner on September 6, 2012. Petitioner is traveling to Dr. Chang's office building on 1:37 pm. At 2:28 pm, Petitioner is seen exiting a Walgreen's carrying a twelve pack of beer (9 lbs) in his right hand and walking out approximately 50 feet to his car. He bends over to set down the beer, opens up the car door, and gets in. He opens a beer and sits in the car with the door open, drinking the beer. At about 2:32pm he puts his foot up on the hinge of the open car door as he sits in the seat, drinking his beer. At 2:40 p.m. he re-enters the Walgreens, and departs again at 2:47pm carrying what appears to be a prescription medication bag. (RX9).

Respondent's Exhibit 9 "RX9" includes surveillance taken of Petitioner on September 13, 2012. Petitioner is seen departing his residence on foot at 12:07 p.m. He walks at a normal speed with no visible limp. He walks 4 city blocks to US Bank, arriving there at 12:24 p.m. He departed shortly thereafter and is seen walking for several minutes to Laciendo Grocery Store. After several minutes inside, Petitioner is seen departing at 12:58 p.m. carrying what appear to be plastic grocery bags filled with items in both hands. He walks home. At various points he carries the bags in one hand, and over his shoulder. He arrives home at 1:15 p.m., after 17 minutes.

Respondent's Exhibit 10 "RX10" includes surveillance taken of Petitioner on November 7, 2013. Petitioner is picking up some food at a drive through at 8:08 a.m. Arrives at 9:16 a.m. at a home in the north side of Chicago. At 9:40 a.m. a work van pulls up and parks behind him. Petitioner and the man from the van exit. Petitioner takes out a bag and work gloves. At 9:41a.m. The man enters the rear of the van and is seen moving around inside. At 9:42 a.m. Petitioner is seen putting on work gloves. He then is seen carrying a milk crate full of what witness Mr. Brooks testified were tools. The other man is seen carrying what appear to be several 10 foot tubes of copper piping. The men enter a residence. No one else is present.

At 10:25 a.m., Petitioner is seen using a drill to drill a hole on the outside of the house through a brick wall. He is standing slightly crouched over and is leaning into the drill as he is manipulating the drill. He periodically removes the drill and leans down to inspect the hole. The drill bit appears to be a foot long. At 10:30 a.m., Petitioner re-enters the home. He returns and begins drilling again at 10:32 a.m.. He is seen angling the drill and leaning on it as he drills through the brick wall. At 10:36, he completes drilling and takes the drill inside. At 1:08 p.m., Petitioner returns outside and is seen placing some kind of material in the holes he drilled. He goes back inside at 1:10 p.m. and comes back out at 1:13 p.m. with a hammer. He then places some material into the hole and starts hammering it. Mr. Morales was installing an exterior spigot onto the side of the house. At 1:17, He is seen leaning onto and fastening the spigot. At 1:50 the men exit the house. At 1:52:46 the man hands the Petitioner a piece of paper that Petitioner reads briefly. The two men are seen laughing and talking for a few minutes after. Petitioner departs at 1:56. Witness Mr. Brooks testified Mr. Morales drove home.

Deposition of Dr. Chang

On December 16, 2013 the parties took the deposition of Dr. Chang. (PX4 at 1). Dr. Chang testified that when he first examined Petitioner, a neurologic exam didn't show any obvious defects. (PX4 at 9). Dr. Chang testified there were no complications during the fusion surgery. (PX4 at 15). He felt that there were no inconsistencies with regard to Petitioner's symptoms and objective findings. Dr. Chang opined that within a reasonable degree of certainty that Petitioner's prognosis was poor and that he was permanently disabled. Dr. Chang acknowledged that after June 7, 2011, the petitioner had a lot of "pain that I cannot explain," so I referred him to a rheumatologist. (PX4 at 20) He explained that "I'm just scratching at everything I can to try to figure out what's causing his pain." (PX4 at 50). Dr. Chang testified the rheumatologist did not help Petitioner's pain. (PX4 at 50).

Dr. Chang explained that he released Petitioner to MMI as of November 15, 2011, and recommended he undergo an FCE. (PX4 at 26). As of January 8, 2013, he reviewed the FCE and felt Petitioner could work at a light duty capacity. (PX4 at 33). He also testified that disagreed with the FCE findings. Dr. Chang stated that the FCE's findings are subjective and that an evaluator meeting Petitioner for the first time did not have the benefits of prior knowledge. Dr. Chang testified that Petitioner cannot put in a meaningful, gainful work day due to this accident. Dr. Chang testified that Petitioner should not work with any heavy equipment, vibratory tools or moving tools. He also would limit him to ground work only with no bending, twisting or squatting.

Dr. Chang testified Petitioner presented the same level of pain in the years since the surgery. (PX4 at 21). Dr. Chang testified Petitioner's pain continued "[d]espite everything that American medical treatment can offer." (PX4 at 42). Dr. Chang testified that he is not sure why the petitioner has post-surgical radiating pain ("there's definitely

nothing pressing on the nerve,") and the EMG did not reveal any great nerve irritation. (PX4 at 48). Dr. Chang testified there is nothing wrong with Petitioner's fusion, and that there is nothing structural causing Petitioner's ongoing pain. (PX4 at 52). Dr. Chang testified the only objective testing corresponding to Petitioner's ongoing pain was the EMG. (PX4 at 52-3). Dr. Chang testified that he expected physical therapy to help, but it did not. (PX4 at 48-9).

Dr. Chang testified that Petitioner could not perform light duty for the whole day, and that he was therefore unable perform any work. (PX34 at 33-34). Respondent's attorney objected to this based on Ghere v. Indus. Comm'n, 278 IllApp. 3d 840, 663 NE2d 1046, 215 Ill.Dec. 532 (4th Dist., 1996) as Petitioner's attorney did not provide this opinion to Respondent's attorney prior to the deposition. (PX3 at 34). The Arbitrator has overruled said objection.

Dr. Chang speculated Petitioner's pain was on a microscopic, cellular level, and that you cannot tell if someone is having pain from a cellular source. (PX4 at 51). He testified there are no tests for determining if someone has cellular pain. (PX4 at 52). Dr. Chang further testified his treatment recommendations and restrictions could change if Petitioner's pain complaints were show to be dishonest. (PX4 at 54). Dr. Chang testified his treatment recommendations and restrictions would change if he determined the petitioner's self-reported limitations were not accurate. (PX4 at 55). Dr. Chang testified Petition is incapable of performing heavy or vibratory work. (PX4 at 58). Dr. Chang testified an automobile qualifies as vibratory machinery. (PX4 at 58). Dr. Chang testified Petitioner can walk for 10 to 15 minutes before he would have to stop and rest. (PX4 at 60). Dr. Chang testified an FCE "where the examiner felt there valid

effort would carry more weight than on where the examiner felt he was inconsistent." (PX4 at 60).

IME Examinations, Dr. Kathleen Weber

On August 9, 2010, Petitioner was examined by Respondent's examiner, Kathleen Weber, M.D. Petitioner informed Dr. Weber that he had no prior history of lower back or left knee pain. (RX1) Petitioner provided a consistent history of the accident and reported that after the incident he felt a burning pain from his back into his legs. Dr. Weber performed a physical examination of both Petitioner's lower back and left knee. Dr. Weber also reviewed x-rays of the lower back and the MRI of the left knee. Dr. Weber's indicated that Petitioner may have a herniated disk and recommended an MRI of the lumbar spine. (RX1) Dr. Weber felt that Petitioner's back condition was related to fall off the ladder. (RX1) As to the left knee, her exam was unremarkable. Dr. Weber indicated that Petitioner related that knee had significantly improved.. Dr. Weber recommended an additional two weeks of therapy for the knee and anti-inflammatory medication. (RX1)

On September 26, 2011, Petitioner was seen a second time by Dr. Weber. Dr. Weber conducted both medical record review and an examination of Petitioner. Dr. Weber diagnosed persistent lumbar pain with L5-S1 radiculopathy. (PX3,p.82) Dr. Weber opined that based on the consistency of Petitioner's complaints from the onset of the injury, Petitioner's diagnosis was causally related to the initial injury and related injury treatment. (Id.) Dr. Weber suggested a CT lumbar scan to verify the fusion was solid. (Id.) Dr. Weber also felt that work conditioning and an FCE were premature. (Id.)

Petitioner was seen for a third time by Dr. Weber on October 29, 2012. Dr. Weber performed record review, reviewed surveillance video and conducted a medical

examination. (RX1) Dr. Weber noted that petitioner complained of bilateral lower back. She stated that he underwent four injections which did not change his symptoms. (Id.) Dr. Weber's diagnosis was chronic lumbar pain, status post L5-S1 fusion, laminectomy and inter body cage. (Id.) Dr. Weber felt that no further medical treatment was necessary other than non-steroidal anti-inflammatory medications. (Id.) Dr. Weber felt that Petitioner could participate in an FCE and maybe a work conditioning program. (Id.)

Deposition of Edward Stefan

On February 17, 2014, the parties took the evidence deposition of Edward Stefan. (RX2 at 1). Mr. Steffan is a vocational rehabilitation counselor at EPS Rehabilitation, who is certified and licensed in the State of Illinois as such. (RX2 at 4, 5). Mr. Steffan testified he took a telephonic labor market survey for Petitioner from November 5, 2013 through December 5, 2013. (RX2 at 6). He testified the labor market survey was used to determine the prerequisite requirements for various jobs, the availability of hiring for those positions, and the associated remuneration. (RX2 at 8-9). He testified he used the FCE, the October 18, 2013 Dr. Chang report, and Petitioner's background as a window washer to determine potential jobs. (RX2 at 8). He then consulted the Dictionary of Occupational Titles to determine the exertion levels of the employment sought so they would correlate with those of Petitioner, as identified by Dr. Chang. (RX2 at 9). He testified he looked for employment within the sedentary level. (RX2 at 9). He testified he looked for employment within the Chicago metropolitan area. (RX2 at 10). The results of this labor market sampling can be found in his December 6, 2013 report. (RX2 at DX2). He found 8 employers with 58 available positions commensurate with the petitioner's physical restrictions and work capabilities. (RX2 at 11). The wages for these positions was between $9 and $12 per hour. (RX2 at

11). The available positions were as: assemblers, fabricators, inspectors, testers, sorters, ushers, attendants, ticket takers, and surveillance officers or monitors. (RX2 at 12). These positions had a wage range of $9.77 to $19.15. (RX2 at 12). Mr. Steffan testified that based on these findings, it was his opinion a stable labor market existed for Petitioner within this pay range. (RX2 at 12). Mr. Stefan testified that the limited telephonic labor market sampling results show the "bottom line" of Petitioner's employability. (RX2 at 14). Mr. Steffan indicated that if the petitioner's physical capabilities were greater than what was provided in the FCE, that the "[g]reater physical capacity should lead to greater access to the labor market." (RX2 at 15). Mr. Steffan testified that a transferrable skill is a skill acquired from performing work that is a component of another type of job. (RX2 at 16). Mr. Steffan testified the only work history he knew of for the petitioner was as a window washer. (RX2 at 16). Mr. Steffan testified that knowing the petitioner's work history might indicate more transferrable skills and lead to greater access to the labor market. (RX2 at 17).

Testimony of Natalie Grijalva

Natalie Grijalva testified she is currently employed as the HR Director for the employer. Prior to that, she was employed as the Operations Manager for the employer, and was working in that capacity from 2010 until her ascension to HR Director. Her job duties included customer service, scheduling both regular and light duty work, and dispatching technicians. She has been the HR Director since mid 2013. Her duties include scheduling work, hiring and firing, and assigning job duties. Before she was hired as the HR Director, she testified there was no one HR position at the employer, and that those duties fell to other employees, including herself and the owner. She testified that the employer has light duty work available, in the form of indoor-only cleaning jobs and

office work. She testified the employer is perpetually understaffed in the office and there is plenty of office work to do. She testified that the nature of the business is seasonal, but that the light duty work is not. She testified the employer could accommodate a 15 pound lifting restriction. She testified she uses the employer's doctor's restrictions and finds work for the employee within those restrictions. She testified that that the employer was capable of accommodating light duty work at the end of 2011, in December 2012, in January 2013. She testified Mr. Morales has never returned seeking light duty work.

Petitioner's Testimony

Petitioner testified during his direct examination that he began working for his cousin in December 2012. (T. 67). Petitioner testified that despite his doctor's restrictions, he worked to earn money for his family. (T. 71). Petitioner testified his cousin is a union carpenter who performs side jobs, and that he hired the petitioner to assist with plumbing. (T. 45-6). Petitioner testified he only helped to supervise other people performing work, that he did nothing heavy, that he did not perform any of the real job tasks, and did not perform any of the fixing or repairing. (T. 46, 47). Petitioner testified he cannot carry and weight or use any heavy or vibrating machinery. (T. 70). Petitioner testified he only performed this work four times since his FCE. (T. 45, 46). Petitioner testified he worked between four and six hours each time he worked for his cousin. (T. 48). Petitioner testified his cousin paid him $120 in cash each time. (T. 47).

During cross examination Petitioner further explained his work activities. He testified that he helped his cousin with plumbing and electrical work. (T. 67). He testified he had no payroll records from his cousin. (T. 67-8). Petitioner testified he could not recall what dates or even seasons he worked for his cousin. (T. 68). However, he stated

that he helped his cousin whenever he calls. (T. 68). Petitioner testified his work for his cousin takes him to the suburbs and the city. (T. 68). He testified he could not remember what parts of the city he worked or any of the suburbs in which he worked. (T. 68). Petitioner testified he is paid in cash by his cousin, and does not report his earnings on his taxes. (T. 69). Petitioner has no documents to show what days he worked, and what days he did not. (T. 69). Petitioner testified he did not tell his doctor about his work activities. (T. 71). Petitioner testified his cousin has no business name, and he did not remember his address. (T2. 44). During rebuttal testimony Petitioner acknowledged that after the first two years he did not present the off work notes to respondent but assumed that the notes were being sent to the insurance company as he was receiving TTD checks. After his FCE was completed he never contacted Respondent to get light duty work. He also claims that they did not contact him either. He explained that the video surveillance tapes show him walking without a limp because his limp is not noticeable. He explained that the video shows him working at a residence where he was simply drilling a larger hole in the outside wall for a plumbing line. He denied working as a plumber but acknowledged that he was drilling a hole in masonry for about 20 minutes. He claimed that when he was inside the house, he was not working but just talking to the owners. He acknowledged receiving cash payment of $120 several times from his cousin for work performed. He also acknowledged that he had lied to Stroger Hospital regarding his ankle injury in New Jersey.

Petitioner testified did not return to Bubbles at that time for light duty work. He testified he did not look for any work at that time.

Petitioner returned to see Dr. Chang on April 9, 2013. (PX3 at 9). At that time, Petitioner continued to complain of persistent lower back and bilateral leg pain. (PX3 at 9). Dr. Chang declared Petitioner had reached MMI and released him from his care. (PX3 at 9). Petitioner testified he last saw Dr. Chang on September 24, 2013, and has not seen anyone else since then.

On October 18, 2013, Dr. Chang authored a report at Petitioner's attorney's request. (PX4, DX2). Dr. Chang reiterated his opinion that Petitioner had permanent 15 pound lifting restriction, as well as restrictions against operating heavy and vibratory machinery, excessive bending/stooping/twisting/climbing, and of a sedentary demand level only. (PX4, DX2).

ANALYSIS/FINDINGS

Causal Connection

Parties have stipulated that Petitioner suffered a wok injury to his lower back on May 22, 2010. Dr. Chang performed a spinal fusion surgery on Petitioner on January 19, 2011 and continued to treat the Petitioner post-operatively with injections, therapy and pain medication through 2013. Petitioner was also examined by IME, Dr. Weber on three separate occasions and underwent an FCE.

The Arbitrator finds Petitioner suffered left knee pain and an aggravation of disc degeneration and a herniated disc at L5-S1 as a result of the work accident, and that the conditions reached MMI by November 15, 2011. A claimant bears the responsibility of proving his claim by a preponderance of the evidence in a workers' compensation hearing. Rambert v. Indus. Comm'n., 133 Ill.App.3d 895, 477 N.E.2d 1364, 1369, 87 Ill.Dec. 836 (Ill.App.2nd. Dist. 1985). The Industrial Commission decides questions of fact, including judging the credibility of witnesses, determining the weight of the

evidence, and resolving conflicting questions of medical evidence. See, Dexheimer v. Indus. Comm'n., 202 Ill.App.3d 437, 442, 559 N.E.2d 1034, 1037, 147 Ill.Dec. 694, 697 (1st Dist. 1990). In this case, Petitioner has proved that his condition of ill-being was causally connected to his work accident but evidence shows that the Petitioner reached MMI by November 15, 2011. Subsequent to this date, the Arbitrator finds that the delay in the FCE and the invalid FCE were both caused by the Petitioner's conduct.

Petitioner first sought medical treatment on May 25, 2010 and complained of low back pain and left knee pain. (RX1 at 2, 3). However, an initial left knee x-ray was negative. (RX1 at 3). When Dr. Weber first examined Petitioner on August 9, 2010, she diagnosed "left knee complaints" that would resolve after two weeks of physical therapy. (RX1 at 3). Petitioner did not treat for his left knee after that time, and did not complain of any left knee condition at the time of trial. Any left knee complaints from the accident resolved quickly and Petitioner did not suffer any permanent disability to the left knee.

Petitioner suffered an aggravation of moderate disc degeneration at L5-S1 that required a lumbar fusion at L5-S1 on January 19, 2011. (PX3 at 41). By August 2011, Dr. Chang opined Petitioner had permanent restrictions. (PX3 at 14). On November 15, 2011, Dr. Chang recommended Petitioner obtain an FCE to determine permanent restrictions, and that he would be at MMI. (PX3 at 16). At his deposition, Dr. Chang confirmed he believed Petitioner had reached MMI as of November 15, 2011. (PX4 at 26).

Dr. Chang, his treating physician had no further treatment recommendations for him, and felt his condition was permanent. Petitioner had improved as far as he medically could. The only thing left to do was to obtain an objective evaluation of his

functional capacity. Petitioner's condition of ill-being up to this point was related to his May 22, 2010 work accident

Following Dr. Chang's November 15, 2011 recommendation, an FCE was scheduled for December 8, 2011. Instead of attending the FCE, which would have allowed a release with permanent restrictions and resulting return to pre-injury employment, return to accommodated duty work, or a possibility for Respondent to provide vocational rehabilitation services, Petitioner allegedly went on a personal trip to New Jersey and injured his left ankle in either a slip and fall or a motor vehicle accident. (T. 35).

Petitioner testified he had surgery on the left ankle in New Jersey. (T. 35). Petitioner underwent surgical removal of an external fixator and open reduction and internal fixation of a left pilon fracture on January 13, 2012. (RX4 at 22). On January 19, 2012, Petitioner appeared at Accelerated Rehab for the FCE.. He was told to return once he had clearance from his ankle doctor as he on crutches. (RX3).

Dr. Chang examined Petitioner on May 22, 2012 and noted he had not yet made a full recovery from ankle surgery. (PX3 at 17). However, he repeated his belief Petitioner had reached MMI regarding his work accident. (PX3 at 17). Petitioner returned to Stroger Hospital on June 6, 2012. (RX4 at 5). There is no office note from that visit. (RX4 at 5). Petitioner testified he never obtained clearance from his ankle doctor because he felt fine and decided to stop treating. (T. 61).

Petitioner finally returned to Accelerated Rehab for an FCE on December 4, 2012. (PX5 at 1). Petitioner presented with 93.8% inconsistent pain ratings, inconsistent effort, and self-limiting behaviors. (PX5 at 2). The FCE found the overall results did not represent a true and accurate representation of Petitioner's overall physical capabilities

and tolerances at the time, and that the results of the evaluation represented only a minimal level of function for Petitioner. (PX5 at 2). Surveillance footage seen at trial and submitted into evidence contradicted Petitioner's reported capabilities in the FCE. During the FCE, Petitioner carried eight pounds bilaterally only 25 feet before he self terminated due to pain. (PX5 at 4). Surveillance taken September 6, 2012 shows Petitioner carrying a full twelve pack of beer, which would weigh more than nine pounds, in one hand a distance of approximately 50 feet without any signs of discomfort or difficulty. (RX9). He is also seen on September 13, 2013 carrying two grocery bags for a seventeen minute walk. (RX9).

Following the FCE, Dr. Chang advised Petitioner could return to work with a fifteen pound lifting restriction as of January 2013 and released him from his care on April 9, 2013. (PX3 at 8, 9). Dr. Chang testified Petitioner's pain complaints have been the same for years since the surgery, and that he had no explanation for these complaints. (PX4 at 20, 21). He testified there was nothing wrong with the fusion, and the only objective finding supporting continued pain was the EMG, which did not reveal any great nerve irritation. (PX4 at 48, 52-3). Dr. Chang testified his treatment and work restrictions have been based on Petitioner being honest with his complaints, and that his opinion could change if he determine petitioner's self-reported limitations were not accurate. (PX4 at 55). Dr. Chang believed Petitioner's pain prevented him from working, operating a car, or operating any vibratory machinery. (PX4 at 60).

Both Petitioner's testimony and the surveillance of November 2013 confirm Petitioner has been working as a plumber, which is a medium to heavy duty job. Petitioner did not tell Dr. Chang this. Petitioner's testimony that he only worked in this capacity four times since his accident is not credible. Petitioner is seen drilling a hole in

a brick wall using a drill he admitted was ten pounds heavy. (RX10). He is also seen using a hammer and twisting and installing a faucet. He can be seen carrying equipment in and out of a house. He likely is performing work on the inside of the house to complete the faucet installation.

At trial, Petitioner testified he has constant pain in his low back and burning in his feet. He testified it is difficult to do anything. (T. 50). He testified he cannot do much around the house. (T. 50). The surveillance video bears witness to a contrary conclusion.

Based on the above, the Arbitrator finds Petitioner's back condition was causally related to his work injury but that he reached MMI by November 15, 2011. .His current subjective complaints are not wholly related to his work the work accident.

Petitioner's Earnings

The Arbitrator finds Petitioner earned an AWW of $794.11. The petitioner testified he was hired by Respondent on April 5, 2010, and was injured on May 22, 2010. Respondent presented payroll records of petitioner's wages during this time period. (RX8) They indicate he worked for only 7 weeks for Respondent. Section 10 of the Illinois Workers' Compensation Act provides that "[w]here the employment prior to the injury extended over a period of less than 52 weeks, the method of dividing the earnings during that period by the number of weeks and parts thereof during which the employee actually earned wages shall be followed." 820 ILCS 305/10. Respondent's Exhibit 8 indicates the petitioner earned $5,558.80 in the 7 weeks of employment before the accident. (RX8). Therefore, the petitioner earned an AWW of $794.11.

TTD Compensation

The Arbitrator finds Petitioner has proved that he is entitled to TTD benefits from May 23, 2010 till November 15, 2011. Respondent has already paid said benefits and is entitled to a credit for the same. Petitioner is claiming TTD benefits through 4/9/13. The Arbitrator finds that the Petitioner reached MMI on November 15, 2011 and is not eligible for TTD benefits beyond that date. Once an injured claimant has reached MMI, TTD benefits may cease even though the claimant may be entitled to receive other permanent total or permanent partial benefits. . Freeman United Coal Min. Co. v. Industrial Com'n, 318 Ill.App.3d 170, 178 251 Ill.Dec. 966, 972 (2000).

A claimant bears the responsibility of proving his claim by a preponderance of the evidence in a workers' compensation hearing. Rambert v. Indus. Comm'n., 133 Ill.App.3d 895, 477 N.E.2d 1364, 1369, 87 Ill.Dec. 836 (Ill.App.2nd. Dist. 1985). The Industrial Commission decides questions of fact, including judging the credibility of witnesses, determining the weight of the evidence, and resolving conflicting questions of medical evidence. See, Dexheimer v. Indus. Comm'n., 202 Ill.App.3d 437, 442, 559 N.E.2d 1034, 1037, 147 Ill.Dec. 694, 697 (1st Dist. 1990). The time during which a claimant is temporarily totally disabled is a question of fact for the Commission; and to be entitled to TTD, claimant must prove not only that he did not work but that he was unable to work. City of Granite City v. Indus. Comm'n, 279 Ill. App. 3d 1087, 1090, 217 Ill.Dec. 158, 666 N.E.2d 827, 828-29 (1996). Petitioner therefore has the burden of proving he was not actually working during the TTD period he claims.

By Petitioner's own admission, he has worked for his cousin since the work accident performing plumbing, electrical, and supervisory work. (T. 67, 45-6). Petitioner testified he performed only supervisory work, did no actual work himself, did no carrying, and did not use any vibratory machinery. (T. 46, 47, 70). Surveillance video

was shown at trial depicting Petitioner performing work himself with now crew, carrying tools, drilling a hole through a brick wall with a ten pound drill, hammering on the wall, bending and twisting, and ultimately fastening a faucet on the wall. (RX10). Petitioner testified his cousin was a carpenter who hired him to do plumbing work. When confronted by the damaging video evidence, Petitioner changed his testimony regarding the type of work he had done

Petitioner testified he only performed this work four times since December 2012. (T. 67, 45). Petitioner claimed he could not remember the dates, the time of year, the name of his cousin's business, or the location of where he worked for his cousin. (T. 68, T2. 44). Petitioner testified he had no documents or paperwork which could show which days he worked. Petitioner claimed he was paid in cash by his cousin, and the surveillance shows Petitioner receiving payment for work (RX10, T. 69). Petitioner admitted he did not report any of his earnings on his taxes.

It is clear that Petitioner was working for his cousin at some point after the accident. The question is whether this work was limited to four days, as Petitioner claims. The Arbitrator finds that the Petition has failed to meet his burden to show that he did not work during the claimed period. Petitioner testimony alone has failed to convince the Arbitrator that Petitioner could not and did not work. Petitioner's testimony on this issue is weak and laced with missing/forgotten details. His attempts at rehabilitating his testimony on cross examination are not convincing. Petitioner appears to be gainfully employed for more then he alleges based on the clear proof in the video tape evidence. The Arbitrator therefore finds Petitioner is not entitled to any TTD benefits beyond November 15, 2011

In addition, Respondent could have accommodated Petitioner's restrictions had he obtained a valid FCE when recommended by his treating physician. To be entitled to TTD, claimant must prove not only that he did not work but that he was unable to work. City of Granite City v. Indus. Comm'n, 279 Ill. App. 3d 1087, 1090, 217 Ill.Dec. 158, 666 N.E.2d 827, 828-29 (1996). Petitioner would have been able to return to work if he had any valid restrictions. Petitioner's FCE restrictions were found to be invalid. Also, Dr. Chang indicated the restrictions he provided were subject to change if he knew Petitioner had misrepresented his pain complaints or functional capacity. Therefore, Petitioner does not have any credible restrictions indicating he would even need light duty work

Natalie Grivalja testified credibly that Petitioner could have been accommodated at work doing inside only window cleaning. He suggested that such accommodation have been offered to other employees in the past. She also testified that Respondent has available office work and indoor cleaning work, as well as ground level work, than can accommodate light duty restrictions. (T. 78). She testified Respondent could accommodate a 15 pound lifting restriction, and could have since 2010. (T. 79, 80-1). She testified Petitioner's position has never been eliminated. (T. 82). Petitioner admitted he had not attempted to return to Respondent for work or conduct any job search.

Based on the above, the Arbitrator finds Petitioner failed to prove he is entitled to TTD benefits beyond November 15, 2011.

Nature and Extent of the Injury

The Arbitrator hereby finds that the Petitioner has failed to prove that he was permanently and totally disabled as a result of his work accident. The Arbitrator finds

that Petitioner suffered permanent injuries equal to 25% of man as a whole due to his work accident relating to his back. The Arbitrator finds no permanency relating to the knee or leg injuries.

Although the Petitioner did suffer a work accident that caused him injuries to this back, the Arbitrator believes that he underwent a successful fusion surgery coupled with extensive physical therapy and light duty work. The Petitioner though his testimony and conduct has called into serious question his credibility and his ability to perform work functions. The surveillance tapes show the Petitioner effortlessly working as a plumber and boring a masonry hole. In the Arbitrator's estimation this qualifies as medium to heavy duty work. Dr. Chang's deposition testimony and post operative EMG show that there is no objective medical finding to corroborate Petitioner's current subjective and continuing complains. Dr. Weber's findings and testimony are credible while Dr. Chang's opinion is marred by the less than honest information provided to him by the Petitioner. Although Arbitrator finds that the back fusion surgery has left the Petitioner with some limitations, the Arbitrator does not find that said limitation cause the Petitioner to be permanently and totally disabled.

There are three ways that a claimant can establish permanent total disability, namely: by medical evidence, by showing a diligent but unsuccessful job effort or by showing that there are no jobs available for a person in their circumstances. A claimant bears the responsibility of proving his claim by a preponderance of the evidence in a workers' compensation hearing. Rambert v. Indus. Comm'n., 133 Ill.App.3d 895, 477 N.E.2d 1364, 1369, 87 Ill.Dec. 836 (Ill.App.2nd. Dist. 1985). The Industrial Commission decides questions of fact, including judging the credibility of witnesses, determining the weight of the evidence, and resolving conflicting questions of medical evidence. See,

Dexheimer v. Indus. Comm'n., 202 Ill.App.3d 437, 442, 559 N.E.2d 1034, 1037, 147 Ill.Dec. 694, 697 (1st Dist. 1990).

First, Petitioner has failed to prove he is obviously unemployable based on the medical evidence. Petitioner testified he last saw Dr. Chang on September 24, 2013. On October 18, 2013, Dr. Chang authored a report stating Petitioner had a permanent 15 pound lifting restriction, as well as restrictions against operating heavy and vibratory machinery, excessive bending/stooping or twisting/climbing type motions. (PX4, DX2). Dr. Chang testified during his December 16, 2013 deposition that Petitioner could not perform light duty for the whole day, and that he was therefore unable perform any work. (PX34 at 33-34). Dr. Chang also testified Petitioner could work a position that accommodated his restrictions, and that the restrictions would change if he determined Petitioner's self-reported limitations were not accurate. (PX4 at 55). The evidence clearly supports that Petitioner was not truthful with Dr. Chang and therefore the Arbitrator is convinced that Dr. Chang's opinion cannot support a finding of medical incapacity of the petitioner. As a result, Petitioner has failed to prove he is obviously unemployable based on medical evidence. .

Additionally, Petitioner has also failed to prove he is permanently disabled under the other two theories.. If a claimant's disability is not so limited in nature that he is not obviously unemployable, or if there is no medical evidence to support a claim of total disability, to be entitled to PTD benefits under the Act, the claimant has the burden of establishing the unavailability of employment to a person in his circumstances; that is to say that he falls into the "odd-lot" category. Ameritech Services, Inc. v. Illinois Workers' Compensation Comm'n, 389 Ill.App.3d 191, 328 Ill.Dec. 612 (2009). The claimant can satisfy his burden of proving that he falls into the "odd-lot" category by showing diligent

but unsuccessful attempts to find work or by showing that he will not be regularly employed in a well known branch of the labor market. Westin Hotel v. Industrial Comm'n, 372 Ill.App.3d 527, 544, 310 Ill.Dec. 18, 865 N.E.2d 342 (2007). Only where an employee proves by a preponderance of the evidence that he falls into the odd-lot category, does the burden of production shift to the employer to demonstrate that the employee is employable in a stable labor market and that such a market exists. City of Chicago v. Illinois Workers' Compensation Commission, 373 Ill. App. 3d 1080, 871 N.E.2d 765 (2007). Petitioner admitted he has worked for his cousin since his surgery. He testified he never contacted his employer or attempted a return to work for them since May 2010. In addition, he testified that since his accident he looked for one job, at Wal-Mart. Clearly, his job search was neither diligent nor unsuccessful. Also, vocational rehabilitation counselor Ed Steffen determined that a stable labor market existed for Petitioner in the Chicagoland area. Therefore, Petitioner cannot prevail under this theory.

Lastly, petitioner is unable to claim a wage differential award. Section 8(d)1 of the Act provides that when a claimant is partially incapacitated from his usual and customary line of employment, he shall receive compensation for the duration of his disability equal to 66 2/3% of the difference between the average amount which he would be able to earn in the full performance of his pre-injury employment and what he is now earning in suitable employment after the accident. 820 ILCS 305/8(d)1. As argued above, Petitioner has been working in plumbing installation, which is a heavy duty position. This indicates he would not be partially incapacitated from his medium heavy job as a window washer. Also, Petitioner has never presented for valid or credible work restrictions, so he has not proved he is incapacitated from any type of

employment. Finally, the Arbitrator notes that Petitioner testified he earned $30 per hour in his recent employment with his cousin. Although, Petitioner testified he only work four times, the Arbitrator finds that he has not proved that he suffered any wage loss. Petitioner has failed to prove is entitled to a wage differential award.

Therefore, the Arbitrator finds that Petitioner has not proved that he is permanently and totally disabled. The Arbitrator finds that the Petitioner did suffer permanent partial disability as a result of this work accident . At trial, Petitioner testified that he fell off a 25-30 foot ladder and injured his back and legs. He states that since the accident he has had consistent and constant pain from his back that radiates to both knees and feet. (T.21). Based on the video evidence, Petitioner' complaints are somewhat inflated. On surveillance, he does not appear to be in constant pain. Petitioner was later seen on surveillance working on November 2013, and was able to bend and lift weight without issue. Petitioner testified at trial he cannot do much around the house. (T. 50). He was seen on surveillance able to perform plumbing installation with a vibrating drill. .

The FCE was invalid, and therefore has little weight in judging Petitioner's true abilities. Dr. Chang testified there were no complications during Petitioner's fusion surgery. (PX4 at 15). He testified the 2012 CT scan revealed a solid fusion. (PX4 at 29-30). Dr. Chang testified the only objective test that could explain post-surgical pain is the EMG, though it did not reveal any great nerve irritation. (PX4 at 48, 52). Also, the EMG did not reveal anything on the left, to explain the left sided leg and foot complaints. Dr. Chang testified his work restrictions and treatment recommendations would change Petitioner's self-reported pain and limitations were not accurate. (PX4 at 54, 55)..

The Arbitrator finds that Petitioner has not accurately reported his work history or his pain condition to his doctor. Also, Petitioner has told the court that he lied to his medical providers at Cook County Hospital so he could avoid paying the bills. The Arbitrator finds that Petitioner is not permanently and totally disable but that he has suffered a 25% loss of use of man as a whole due to his back injuries.

Respondent's credit

The Arbitrator finds Petitioner was entitled to TTD benefits from May 23, 2010 through November 15, 2011, for a total of 77 3/7 weeks, at a rate of $529.41, for a total of $40,991.28.

Parties have stipulated that Respondent is entitled to a credit of $68,509.73. Respondent shall receive credit for overpayment of 27,518.45.

Ketki Steffen
Arbitrator Ketki Shroff Steffen

June 4, 2014
Date

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Judy Rambert,

Petitioner,

vs.

NO. 08WC 39129

Sunrise Senior Living,

15IWCC0056

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of temporary disability, causal connection, medical expenses, prospective medical and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 18, 2014 is hereby affirmed and adopted.

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

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

No bond is required for removal of this cause to the Circuit Court by Respondent.

15IWCC0056

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: JAN 2 1 2015
SJM/sj
o-1/15/15
44

Stephen J. Mathis

Mario Basurto

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

RAMBERT, JUDY
Employee/Petitioner

Case# **08WC039129**

15IWCC0056

SUNRISE SENIOR LIVING
Employer/Respondent

On 2/18/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.11% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0140 CORTI ALEKSY & CASTANEDA
MARK DePAOLO
180 N LASALLE ST SUITE 2910
CHICAGO, IL 60601

0766 HENNESSY & ROACH PC
ERIN FIORE
140 S DEARBORN 7TH FL
CHICAGO, IL 60603

15IWCC0056

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

Judy Rambert
Employee/Petitioner

v.

Sunrise Senior Living
Employer/Respondent

Case # 08 WC 39129

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 19, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **July 14, 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 (left shoulder, cervical – neck) *is not* causally related to the accident.
Petitioner's current condition of ill-being (right arm) *is* casually related to the accident.

In the year preceding the injury, Petitioner earned $ 21,923.72; the average weekly wage was $421.61.

On the date of accident, Petitioner was 45 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 **$5,260.02** 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

Causation
Petitioner's current condition of ill-being (left shoulder, cervical – neck) is not related to the work accident of July 14, 2008.
Petitioner's current condition of ill-being (right arm) is related to the work accident of July 14, 2008.

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $281.07/week for 17-2/7 weeks, commencing 04-22-09 through 08-20-09, as provided in Section 8(b) of the Act.

Credits
Respondent shall be given a credit of $ 5,260.02 for TTD paid. Respondent is entitled to an overpayment of $401.44.

Medical benefits
No medical bills are awarded as: (1) Petitioner did not establish the medical necessity of the Chiro-Med Health and Wellness Center treatment, and (2) Petitioner did not establish that her current condition of ill-being (cervical – neck) is causally connected to the original work accident of July 14, 2008.

Prospective Medical Care
Petitioner is not entitled to any prospective medical care and is not entitled to the surgery as proposed by Dr. Templin.

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

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

Signature of Arbitrator

02-18-14
Date

FEB 18 2014

STATE OF ILLINOIS)
) SS
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JUDY RAMBERT,	)	
	)	
Petitioner,	)	
	)	
vs.	)	No. 08 WC 39129
	)	
SUNRISE SENIOR LIVING,	)	
	)	
Respondent.	)	

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Both parties have stipulated that Petitioner's right shoulder injury and treatment are compensable under the Act. The focus of the following memorandum is whether Petitioner's left arm and cervical condition are casually related to the accident.

I. Accident

Petitioner testified that she was employed by Sunrise Senior Living on the date of the accident of July 14, 2008. She testified that she had been employed by Respondent for 10½ years.

Petitioner testified that on July 14, 2008, she was at the front desk and witnessed a resident falling backwards. She testified that she ran to stop him and grabbed his belt above his butt with her right hand and both fell to the floor. She indicated that she felt pain in her bicep all the way to her right shoulder and neck.

II. Medical Treatment

Petitioner testified that she originally treated at Advocate Occupational Health. She states that her employer sent her to his provider. Petitioner complained of pain in the right upper arm that radiates down her entire right arm, causing shaking to the arm. P. Ex. 1. She then proceeded to treat with her primary care physician, Dr. McKeigue.

Dr. McKeigue prescribed an MRI, which was performed on July 30, 2008, and revealed (1) AC joint degeneration changes and acromial downslope with underlying bursal surface degeneration and tendonitis of the supraspinatus without full thickness rotator cuff tear or retraction; and (2) altered size and morphology of the superior, anterior and posterior labral structures and marked attenuation of the labral attachment of the long head biceps tendon -

consistent with a labral tear and partial thickness biceps tendon tear. P. Ex. 3. Dr. McKeigue also prescribed physical therapy, P. Ex. 2, which Petitioner attended at Sun Rehab Therapy Center. P. Ex. 3.

Petitioner indicated that she stopped attending physical therapy and then presented to another doctor. She indicated that she chose from a list of doctors provided by her attorney and that she chose Dr. Leah Urbanosky of Hinsdale Orthopaedics because she was a female, close to home and board certified. Petitioner first presented to Dr. Urbanosky on September 13, 2008. P. Ex. 5. Petitioner reported an injury to her right shoulder and biceps with numbness and tingling in the right hand. Id. She also reported that she felt a tear at the time of the injury. Id.

Petitioner testified that she was then referred to physical therapy and attended same at ATI. She testified that through this time she felt pain in the top part of her shoulders, upper neck into the base of her skull. She further testified that she told her therapist about this pain from her shoulder up to her neck.

The ATI records indicate that Petitioner underwent a shoulder evaluation on September 29, 2008. The pain diagram indicated pain in the right shoulder, chest and shoulder blades. Under subjective complaints, it indicates that Petitioner complained of pain in the shoulder, upper arms and down to the elbow. The daily notes document the first report of neck pain to be on October 30, 2008. The discharge summary on November 17, 2008, indicated that Petitioner had complaints of cervical stiffness/spasm. That is documented nowhere in the daily notes. P. Ex. 6.

Petitioner underwent an EMG of the right upper extremity on November 14, 2008, It revealed no evidence of neuromuscular disease, mononeuropathy, cervical radiculopathy, nor plexopathy. P. Ex. 5.

Petitioner then attended an independent medical examination with Dr. Jay Pomerance on December 4, 2013. R. Ex. 2. He was unable to provide full opinions without additional documentation. Id. The additional documentation was forwarded to the doctor and he drafted addendum opinions on January 16, 2009, R. Ex. 3, and February 1, 2009. R. Ex. 4.

Petitioner continued to treat with Dr. Urbanosky. Petitioner's first document report of neck pain to Dr. Urbanosky was on March 13, 2009. P. Ex. 5. Dr. Urbanosky recommended surgery, id., which Petitioner testified that surgery was initially denied.

Eventually, surgery was authorized and Petitioner underwent same at Silver Cross Hospital on April 22, 2009. She testified that she underwent same day surgery and went home later that day. She testified that she was in severe pain when she returned home as her bladder had not woken up and that she had to return to the hospital. She stated that she went back to the emergency room at Holy Cross Hospital and was admitted for four days. She was restricted from working as of the surgery date. P. Ex. 7.

Shortly thereafter, Petitioner began another course of physical therapy for the right arm and shoulder at ATI Physical Therapy. P. Ex. 6. Eventually, her medications were changed and she began consuming Norco.

Petitioner testified that from May to June 2009, she continued to tell the therapist at ATI that she had problems with the right side of her neck, and the ATI records corroborate same. Petitioner testified that the pain in her neck is a severe tightness, "like a brick," and that it gives her severe headaches. Petitioner testified that the therapist at ATI massaged her neck and treated her for her neck symptoms. She further testified that her neck was not getting better and was actually getting worse. She indicated that the therapy massages would help short term only.

Petitioner testified that as of August 21, 2009, Respondent was able to accommodate her light duty restrictions. The parties stipulated that Petitioner was paid TTD benefits from April 22, 2009 through August 20, 2009.

Petitioner testified that she continued to attend therapy at ATI. She testified that she was experiencing daily neck pain. The ATI daily notes document various complaints of headaches and neck pain. However, there are daily notes that indicate on certain days Petitioner reported no neck pain or decreased neck pain. Petitioner further testified that the therapy became less about her arm and more about her neck as her arm was improving. The ATI "Program Treatment Flow Sheet" indicates that Petitioner progressively performed additional exercise. P. Ex. 6. However, the daily notes do not indicate any chance in treatment and, in fact, document continued arm therapy through Petitioner's discharge on September 24, 2009. Id. The ATI records also document that Petitioner received soft tissue mobilization on multiple dates of service. Id.

Petitioner testified that by October 2009, she was continuing to advise Dr. Urbanowsky that she still had pain in her shoulder up to her neck. Petitioner testified that the pain was on the right side of the neck from the top of her right shoulder up to the base of her skull. Regardless, Dr. Urbanowsky released her with permanent restrictions of lifting no more than 20 pounds on October 28, 2009. P. Ex. 5.

III. Disputed Medical Treatment

Petitioner testified that Dr. Urbanowsky recommended that she receive chiropractic care to address her ongoing pain symptoms. However, Dr. Urbanowsky's release from care on October 26, 2009, did not list a referral to a chiropractor. Regardless, Petitioner then began receiving chiropractic care from Dr. Miller at Chiro-Med Health and Wellness Center. This Arbitrator notes that Dr. Miller's initial treating records do not indicate a referral, either. P. Ex. 8. Petitioner testified that Dr. Miller would move her neck around and use an electric device to loosen her muscles. Petitioner testified that she felt okay when she left the therapy but her symptoms returned to the scene the next day. Petitioner testified that Dr. Miller's treatment was not authorized by her employer. Respondent submitted a utilization review dated February 9, 2010, stating that the chiropractic care was not medically necessary. R. Ex. 7. Petitioner continued to treat with Dr. Miller through May 2010 and was released from his care on May 10, 2010. P. Ex. 8.

Petitioner returned to Dr. Urbanowsky on May 17, 2010, for a one year follow up. Petitioner reported that her shoulder was better but that the trapezius complaints were still significant. On physical examination, Petitioner demonstrated good rotator cuff strength and range of motion. She had tenderness in the trapezius and lavatory scapula, as well as the right cervical musculature up the neck. Dr. Urbanosky referred Petitioner to pain management through a Dr. Marie Kirincic, who evaluated Petitioner on June 9, 2010. P. Ex. 5.

Petitioner testified that Dr. Kirincic recommended physical therapy, which was denied, injections and acupuncture. Petitioner testified that she did not receive relief from the injections and the acupuncture did not help her. On July 2, 2010, Petitioner presented with complaints of left cervical pain radiating down her left arm all the way to each finger. The office visit note does not document any kind of trauma for the left sided symptoms. P. Ex. 5.

Petitioner underwent an additional MRI of the right shoulder on July 8, 2010. The findings from that study are: (1) mild spondylotic changes; (2) left paracentral disc protrusion or herniation at C6-7 causing mild canal stenosis with asymmetric effacement of the left lateral recess and asymmetric stenosis of the left neural foramen; (3) mild stenoses at C5-6, slightly greater on the left; and (4) posterior right thyroid nodule – consider ultrasound correlation. P. Ex. 5.

Petitioner testified that Dr. Kirincic recommended her to see an orthopaedic surgeon, Dr. Templin. See P. Ex. 5. She was attending ongoing therapy and traction at ATI. P. Ex. 6. However, she indicated she had severe pain and headaches and that she would get the pain simply from using her arms.

Petitioner testified that during this time, although she would have pain from everyday activity, that she had to lift juice containers at work which really aggravated her neck. Petitioner testified that when full, the juice containers may weigh 15 to 18 lbs. During this time, she testified that the pain began down her left arm and that it started in July 2010.

Petitioner was evaluated by Dr. Templin on August 4, 2010. She complained of neck pain extending to the right peritrapezial region and occasionally into the arm as well as into the left arm. P. Ex. 5. Petitioner reported that the left arm pain occurred after she returned to work from the right shoulder. Id. The doctor documented that "She notes that the problem began suddenly, and prior to this she had no episodes of neck pain or arm pain, and things have gradually worsened since the time of her injury." Id. Petitioner testified that she was recommended to undergo a set of injections with Dr. Patel.

Petitioner also underwent another EMG, this time to the bilateral upper extremities. The exam took place on September 3, 2010. The conclusion was that there is evidence of left C7 radiuclopathy and C5-6 radiculitis. R. Ex. 5.

Petitioner underwent an independent medical examination with Dr. Zelby on September 8, 2010. Dr. Zelby addressed Petitioner's new constellation of left sided neck symptoms and opined that they were not related to the original work accident. R. Ex. 6.

At that same time, Petitioner presented to Dr. Kirincic for follow up and Dr. Kirincic drafted a report/office visit note on October 7, 2010. Dr. Kirincic agreed that she did not know why Petitioner had a new constellation of symptoms on the left side and that she did not believe they were related to the work accident. Dr. Kirincic noted that Petitioner had no prior complaints of left upper extremity pain. She also reviewed the Hinsdale Orthopedic chart, therapy notes, chiropractic notes and the independent medical evaluation and similarly found no complaints of left upper extremities. Dr. Kirincic stated, "I agree with IME, that the current disc abnormalities and left sided radiculopathy is not clearly caused or made symptomatic as consequence of any work injury or work activity, unlike her right shoulder, which was clearly delineated to be a work related injury. I also do not believe that because of favoring the non-surgical arm, her left sided symptoms appeared ... even though I have been closely involved with this Ms. Rambert case and treatment, I have to admit that I do not have clear explanation for patient's sudden development of left upper extremity symptoms as no injury has been reported. Her left sided cervical radiculopathy since July 2, 2010, could be a natural progression of pre-existing degenerative process." R. Ex. 8.

Petitioner reported at the November 23, 2010, follow up visit with Dr. Templin that she suffered some sort of lifting or twisting accident with juicing equipment in June or July. She reported that it caused the acute onset of neck and left arm pain. P. Ex. 5.

Petitioner did undergo the injections with Dr. Patel. The first was administered on October 22, 2010. Petitioner testified that the injection helped and that the pain down her left arm subsided. Petitioner testified that she underwent the second injection on November 8, 2010, and that it helped even more. Petitioner's third injection occurred on December 6, 2010, and Petitioner testified that she had no more radiating pain down her left arm and that there was just a little bit of tingling in her hands. See P. Ex. 9.

Petitioner testified that Dr. Templin thereafter returned her to work. The Hinsdale Orthopeadics records indicate that on December 27, 2010, Dr. Templin released Petitioner to follow up on an as needed basis only. P. Ex. 5.

Petitioner presented to Dr. Kirincic for follow up on March 11, 2011. Petitioner testified she was having the same pain as before, with soreness in the right neck with muscle spasm, and that her left arm and right bicep were still good. She continued taking Norco and continued to suffer from headaches. Petitioner testified that she continued to see Dr. Kirincic during this time.

Petitioner testified that on February 10, 2013, she presented to the Silver Cross Emergency Room. She testified that her neck would tighten up so hard that she would get severe headaches and experience nauseousness. Petitioner later testified that she would present to the emergency room (as she has on multiple occasions), and they would place her on an IV and give her medicine and a muscle relaxer that would help the pain immediately.

By March 2013, Petitioner began to experience tingling on the right side of her arm. She underwent another MRI on March 25, 2013, and the study revealed multilevel spondylotic changes with no significant change from the July 8, 2010 MRI. After review of the MRI, Dr. Kirincic referred Petitioner back to Dr. Templin. Dr. Templin's interpretation of the MRI was

bilateral foraminal stenosis at C5-6, right greater than left, and C6-C7 foraminal stenosis, left greater than right which was somewhat improved. P. Ex. 5.

Petitioner again presented to the emergency room at Silver Cross Hospital on July 8, 2013. She stated she was experiencing severe pain in her neck and into both arms. She testified that she had been pulling on a patient that day and that it increased her pain. She indicated there was nothing different about the activity and that it was an everyday type of movement.

Petitioner testified that Dr. Templin is now recommending a two-level surgery to her neck. Petitioner could not remember the name. Dr. Templin drafted a narrative opinion, dated July 10, 2013, that reviewed Petitioner's symptoms, his opinion that her current symptoms are related to the work accident of July 14, 2008, and his recommendation for an anterior cervical discectomy and fusion at C5-C6 and C6-C7. He reviewed Petitioner's treatment course, noting Petitioner's consistent reports of pain extending to the right periscapular area until she suffered a herniated disc at C6-7, extending to the left and causing severe C7 radiculopathy. Dr. Templin notes that this would not be entirely attributable to the work injury, although Petitioner was reporting that she believe it started from lifting some type of juicing equipment. Dr. Templin goes on to state that she also likely had an aggravation of C5-6 foraminal stenosis. He opines that the right sided symptoms, which have been present from the beginning, are more likely than not related to the work accident of July 14, 2008. He recommends an anterior discectomy and fusion at C5-6 and C6-7 to return her to her pervious level of function and to allow her to resume normal work activities. P. Ex. 5.

Petitioner also attended another independent medical examination with Dr. Zelby on August 15, 2013. R. Ex. 9.

IV. Respondent's Independent Medical Examinations

Petitioner attended an independent medical examination, performed by Dr. Jay Pomerance, on December 4, 2008. Pomerance noted that the patient's subjective complaints appear to outweigh the objective findings. He noted that in reviewing her prior medical records, she has a history of symptom magnification and a low threshold for pain. He notes that the MRI from July 30, 2008, showed degenerative findings and no evidence of full thickness tendon tears. Dr. Pomerance requested a description of Petitioner's actual job duties and a copy of the MRI film. He indicated that her job duties as a concierge would not be restricted. He did not opine as to causal connection in this opinion. Dr. Pomerance did opine, based upon the report of the MRI, that Petitioner's changes were related to degeneration in the acromoclavicular joint. Dr. Pomerance requested an MRI and description of her job duties and more descriptive data concerning how the alleged work accident actually occurred. R. Ex. 2.

On January 16, 2009, Dr. Pomerance issued an addendum report after reviewing Petitioner's MRI scan. He noted that the MRI was done without contrast and that these studies have low sensitivity and specificity in diagnosing labral pathology. He recommended obtaining an MRI with contrast as a non-surgical option to determine Petitioner's shoulder complaints. He noted that while surgery could be considered, it did not appear that there were findings consistent

with an acute trauma or related to an event on July 14, 2008, as described by Petitioner. He also asked for additional information regarding the alleged accident. R. Ex. 3.

On February 1, 2009, Dr. Pomerance issued another addendum report. He stated, "to date, all of the objective information regarding the patient's shoulder condition is consistent with chronic degenerative changes." He later goes on to again state that an MRI with contrast could help determine if there was a labral tear. He states that if a new MRI shows labral detachment, it would be consistent with a work injury on July 14, 2008. He states that if there is no detachment and all the findings are degenerative, then it would not appear that the work accident caused structural alteration to Petitioner's shoulder. R. Ex. 4.

On August 20, 2009, Petitioner presented for an additional independent medical examination with Dr. Pomerance. Dr. Pomerance reviewed Petitioner's treatment after her surgery as well as the operative report. He stated that Petitioner's care, to date, had been within the community's standard. He anticipated that within the next four to six weeks, Petitioner would be transitioned from her current physical therapy regimen to a home exercise program. He noted that there was no medical reason to prevent her from doing her prior regular duties. He stated there is no need for work restrictions. He lastly stated that he expects Petitioner to be at maximum medical improvement within six months from the time surgery is completed. R. Ex. 5.

Due to the new left sided and cervical symptoms, Respondent requested that Petitioner attend an independent medical examination with Dr. Andrew Zelby. The examination occurred on September 8, 2010. Petitioner gave her medical history pertaining to the work accident. Dr. Zelby documented that Petitioner state her left upper extremity pain began around November of 2009 without reference to any specific incident. She also reported that she thought her symptoms began due to the repetitive activity she performed at work. Dr. Zelby noted from review of the records that Petitioner developed left upper extremity radicular complaints in July 2010 and he related these to a disc abnormality at C6/C7. He noted that Petitioner's theory that repetitive activities at work brought on the symptoms are not reflected in the medical records and additionally that a herniated disc is not a condition of repetitive trauma. He stated, "this completely new constellation of symptoms did not arise or become symptomatic as a result of any work injury or work activity. Ms. Rambert's herniated disc and the left upper extremity symptoms have been treated appropriately, and consideration for both epidural steroid injections and possible surgery is reasonable, but unrelated to any industrial accident or activity, and should be treated as such." He further states that any radiographic abnormalities in her cervical spine are completely unrelated to the work incident. He further states that any inability to do work or non work related activities are not related to the work injury or her alleged repetitive work activities. R. Ex. 6.

Petitioner attended another independent medical examination with Dr. Zelby on August 5, 2013. He documented Petitioner's history, noting she reported constant right sided pain and spasm and severe headaches. She reported no new injuries since 2008. Dr. Zelby reviewed the MRI of March 25, 2013, noting the interpreting radiologist's summary of the findings and the fact that Dr. Templin claims the pathology at C5-6 is right greater than left, in direct contradiction to the report. He also reviewed the updated medical records from Dr. Urbanosky,

Dr. Kirincic, Dr. Templin and Dr. Patel. Dr. Zelby opined that the work accident or resulting treatment did not cause any of the symptoms related to Petitioner's spine or nervous system. He further opined that Petitioner's right sided complaints are not caused by the cervical spine pathology. Dr. Zelby reviewed the MRI pathology and the EMG findings, noting they are all primarily to the left. He disagrees with Dr. Templin's opinion that surgery is indicated in this case as Petitioner's symptoms have not resolved. He explained that:

> Continued complaints of pain in the context of findings on a diagnostic studies like her cervical MRIs that do not correlate with those complaints does not lead to a condition that can be corrected with surgery and is not a justification to pursue a surgery. An anterior cervical discectomy and fusion for Ms. Rambert would be treatment of a radiographic abnormality that is causing no identifiable symptoms and no neurologic infirmity for the patient. Because of that, there is no reasonable expectation that surgery would reduce her subjective complaints.

Dr. Zelby opined that Petitioner did not need any additional treatment to the spine and should wean from all narcotic medications. He opined that she was at maximum medical improvement a long time prior for the shoulder, and likely at least from 2010 for the cervical spondylosis. He recommended that she engage in a diligent, daily, home exercise program. He opined that she needs no restrictions referable to the cervical spine but noted the permanent restrictions related to the right shoulder. R. Ex. 9.

Dr. Zelby drafted an addendum report after personal review of the MRI from March 25, 2013. He interprets the MRI to show maintained cervical lordosis. There is a miniscule disc/osteophyte complex and minimal left uncovertebral joint hypertrophy, without stenosis, at C2-3. There is moderate broad-based disc/osteophyte complex, with very mild left lateral recess and foraminal stenosis at C3-4. There is broad-based disc/osteophyte complex, with very mild effacement of the ventral CSF and minimal left greater than right formainal stenosis at C4-5. There is a broad based disc/osteophyte complex, as well as a left-sided disc protrustion of superimposed left disc/osteophyte complex, with partial effacement of the CSF, resulting in mild right lateral recess and foraminal stenosis, with moderate-moderately severe left lateral recess stenosis and moderate left foraminal stenosis at C5-6. Lastly, there is modest broad-based disc/osteophyte complex with partial effacement of the ventral CSF, and a superimposed left lateral foraminal disc/osteophyte complex at C6-7. He summarizes it to show mild right foraminal stenosis, with moderate left lateral recess and foraminal stenosis. Dr. Zelby states that there is poor correlation of symptoms with the radiographic findings and states there is no medical basis to pursue surgery to the cervical spine. He again opined that there is no reasonable expectation that the surgery would provide any meaningful or sustained relief. He also opined that the likelihood of improving neck pain with an anterior discectomy and fusion, in the absence of frank spinal cord compression, is poor. R. Ex. 10.

V. Petitioner's Current Condition

Petitioner testified that she wants to proceed with the surgery as recommended by Dr. Templin.

Petitioner also testified that there were three additional emergency room visits since the IME with Dr. Zelby. Petitioner testified that the most recent emergency treatment was on November 17, 2013. This Arbitrator notes that there are no records relating to same contained within Petitioner's Exhibit 7.

On cross-examination, Petitioner testified that she had had no prior injuries to her shoulder or neck area. When asked about her current symptoms, Petitioner testified that her complaints are only on the right side. She also testified that she is still under the work restrictions of lifting no more than 20 lbs. and that she continues to work, accommodated duty, for Respondent.

Petitioner was also cross-examined regarding any prior or new work accidents. Petitioner testified that she did sustain a new work accident when she lifted the juicing equipment in July 2010. Petitioner testified that she reported same to her employer. This Arbitrator notes that there were no accident reports submitted at trial regarding same. Additionally, this Arbitrator notes that the Request for Hearing form only indicates an accident date of July 14, 2008.

VI. Bills

Petitioner submitted a summary of outstanding bills as Petitioner's Exhibit 10. Those bills total $52,443.43. The parties stipulated that the only bill that must be addressed in this Arbitrator's Decision would be that of Chiro-Med Health and Wellness Center. Petitioner's bill summary indicates that Chiro-Med Health and Wellness Center charged a total of $9,640.00 for services rendered from January 11, 2010, through April 19, 2010. The summary also indicates that Respondent has paid $0 to Chiro-Med Health and Wellness Center.

Respondent submitted a copy of its payment listing as Respondent's Exhibit 1. The exhibit contains 50 pages of medical payments to various providers.

DECISIONS OF LAW

F. In Support Of The Arbitrator's Decision As It Relates To Whether Petitioner's Current Condition of Ill-Being is Causally Related to the Injury, The Arbitrator Finds The Following:

This arbitrator finds that Petitioner's current condition of ill being (cervical and left shoulder) is not causally related to the work injury of July 14, 2008. This arbitrator relies on the opinions of Dr. Kirincic and Dr. Zelby in support of his finding. This arbitrator also relies, in part, on Petitioner's testimony regarding what caused her increased pain and symptoms.

It is Petitioner's burden to establish that her current condition of ill-being is causally connected to the work accident. There is no clear medical opinion that Petitioner's left sided arm complaints are related to the work accident. Dr. Kirincic could find no causal connection and indicated her agreement with Dr. Zelby in her October 7, 2010, opinion. Dr. Zelby has opined in each of his reports that Petitioner's left sided complaints are not related to the work accident of

July 14, 2009. Lastly, Dr. Templin could not form an unequivocal opinion as to the relation of the left-sided complaints and stated that they are not completely attributable to the work accident.

The causal connection of Petitioner's neck complaints is less clear and the arbitrator finds the opinions of Dr. Zelby to be more credible than that of Dr. Templin. This arbitrator notes that Dr. Templin began treating Petitioner on August 4, 2010, but did not provide a causation opinion until July 2013. Dr. Templin bases part of his opinion on an undocumented accident involving juicing equipment, even noting that accident history was not documented previously. This arbitrator also notes that Dr. Templin's review of Petitioner's March 25, 2013, MRI differs from that of the interpreting radiologist, Dr. Krincic and Dr. Zelby. Dr. Templin's opinion is that Petitioner's pathology is more severe on the right side but provides no explanation for the difference in opinion. All of the other physicians interpreted the MRI to show mainly left sided pathology. Not only was the doctor's opinion drafted in anticipation of litigation, it was not based on full facts. For those reasons, Dr. Templin's causation opinion is not credible.

Instead, this arbitrator finds the opinions of Dr. Zelby to be more credible than those of Dr. Templin. Dr. Zelby provides an opinion based on the objective findings in this case. Dr. Zelby personally reviewed the MRIs of July 8, 2010, and March 25, 2013. He acknowledges the pathology within the cervical spine, but notes that a surgery to address same would not address Petitioner's right sided symptoms. Petitioner's own testimony was that she only suffers from right sided pain at this time. Dr. Zelby's opinion that the surgery is not reasonable in this case, nor that it would provide any kind of significant relief for Petitioner's right sided symptoms, is the most credible opinion submitted at trial.

Lastly, Petitioner's own testimony contradicts that her current condition of ill being is related to the July 14, 2008, accident. It is undisputed that Petitioner suffered an injury at work on July 14, 2008, after trying to catch a falling resident. However, Petitioner testified that she suffered another accident in June or July 2010 while lifting or changing juicing equipment. This was not documented anywhere in the medical records created near the time of the alleged event and this arbitrator questions the claim itself. But this arbitrator notes that Petitioner later reported the allegation to Dr. Templin and testified as to same at arbitration. She further testified at arbitration that the juicing incident is what really aggravated her pain. The parties stipulated that the arbitration hearing was about one work accident on July 14, 2008. Although the arbitrator cannot comment on the compensability of any new accident, this arbitrator does find that Petitioner has not sustained her burden of proving that her current condition of ill-being is related to the July 14, 2008, accident.

J. **In Support Of The Arbitrator's Decision As It Relates To Reasonable and Necessary Medical Services and Whether Respondent Paid All Appropriate Charges For All Reasonable And Necessary Medical Services. The Arbitrator Finds The Following:**

This arbitrator finds that Petitioner is entitled to the following under Section 8(a) of the Act as it relates to medical bills.

This arbitrator awards payment of the Athletic & Therapeutic Institute bills incurred through October 26, 2009. Respondent must pay any outstanding bills incurred through October 6, 2009, pursuant to the Illinois fee schedule. Respondent is granted a credit for any and all bills already paid to Athletic & Therapeutic Institute.

This arbitrator awards no bills from Chiro-Med Health & Wellness Center as the chiropractic treatment was not medically necessary. First, this arbitrator notes that Petitioner's treating physician did not document any referral for chiropractic care. Second, this arbitrator finds Respondent's utilization review, finding the chiropractic care not certified, to be persuasive. Lastly, Petitioner testified that she experienced very limited relief from the treatment.

This arbitrator awards payment of the EM Strategies, Ltd., bills incurred on April 22, 2009. Respondent must pay any outstanding bill pursuant to the Illinois fee schedule. Respondent is granted a credit for any and all bills already paid to EM Strategies, Ltd.

This arbitrator awards payment of the Hinsdale Orthopaedic Associates bills incurred through May 17, 2010. Any bills incurred after May 17, 2010, are not causally connected to the July 14, 2008, accident. Respondent must pay any outstanding balance pursuant to the Illinois fee schedule. Respondent is granted a credit for any and all bills already paid to Hinsdale Orthopaedic Associates.

This arbitrator awards no bills from Injured Workers' Pharmacy as the medications dispensed are not causally connected to the work accident of July 14, 2008.

This arbitrator awards no bills from Medical Solutions as Petitioner submitted no bills in support of her claim. This arbitrator finds that the summary of balances is not sufficient to establish the reasonableness or necessity of the alleged outstanding bill.

This arbitrator awards no bills from Pain & Spine Institute as the treatment rendered is not related to the work accident of July 14, 2008.

This arbitrator awards no bills from Pathology lab as Petitioner submitted no bills in support of her claim. This arbitrator finds that the summary of balances is not sufficient to establish the reasonableness or necessity of the alleged outstanding bill.

This arbitrator awards no bills from Silver Cross Hospital as the bill is unrelated to the work accident of July 14, 2008.

K. **In Support Of The Arbitrator's Decision As It Relates To Temporary Total Disability Benefits, The Arbitrator Finds The Following:**

This arbitrator finds that Petitioner is entitled to TTD from April 22, 2009, through August 20, 2009, or 17-2/7 weeks of compensation. This arbitrator notes that TTD was paid at a rate of $281.07, and Petitioner is entitled to $4,858.58. The parties stipulated that Respondent paid $5,260.02 in TTD benefits. Therefore, Respondent is entitled to a TTD credit of $401.44.

O. **In Support Of The Arbitrator's Decision As It Relates To Prospective Medical Care, The Arbitrator Finds The Following:**

This arbitrator finds that Petitioner is not entitled to any prospective medical care as Petitioner's current complaints are not related to the work accident of July 14, 2008. This arbitrator declines to award Dr. Templin's proposed anterior cervical discectomy at C5-C6 and C6-C7 as it is not causally connected to the work accident of July 14, 2008.

ARBITRATOR

02-18-14

DATED AND ENTERED

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

Theodore Pernice,

Petitioner,

vs.

NO. 12 WC 43518

Hill Mechanical,

15IWCC0057

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 3, 2014 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 $20,900.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JAN 2 1 2015

Stephen J. Mathis

SJM/sj
o-1/15/15
44

Mario Basurto

David L. Gore

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

PERNICE, THEODORE J
Employee/Petitioner

Case# **12WC043518**

15IWCC0057

HILL MECHANICAL
Employer/Respondent

On 4/3/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.06% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2221 VRDOLYAK LAW GROUP LLC
MICHAEL P CASEY
741 N DEARBORN 3RD FL
CHICAGO, IL 60610

1120 BRADY CONNOLLY & MASUDA PC
MARK F VIZZA
10 S LASALLE ST SUITE 900
CHICAGO, IL 60603-1016

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)

Theodore J. Pernice
Employee/Petitioner

v.

Hill Mechanical
Employer/Respondent

Case # 12 WC 43518

15IWCC0057

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Deborah L. Simpson**, Arbitrator of the Commission, in the city of **Chicago**, on **October 13, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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 _____

15IWCC0057

FINDINGS

On the date of accident, **September 27, 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 **$93,704**; the average weekly wage was **$1802.00**.

On the date of accident, Petitioner was **37** 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 **$3,776.59** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$3,776.59**.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $1,201.97 / week for 20 3/7 weeks commencing October 18, 2012 through November 28, 2012, (6 weeks) and February 18, 2013 through October 10, 2013,(33 5/7 weeks) a total 39 5/7 weeks, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner TTD benefits that have accrued from October 18, 2012 through November 28, 2012 and February 18, 2013 through October 19, 2013, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall pay reasonable and necessary medical expenses with respect to the testing and treatment that Petitioner received for his lower back and leg, hip and groin, pursuant to the medical fee schedule or by prior agreement, whichever is less, pursuant to the Act.

Respondent shall be given credit for $3,776.59 for TTD that has been previously paid.

Petitioner's request for attorney's fees and penalties is denied.

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

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

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

Deborah L. Simpson
Signature of Arbitrator

April 1, 2014
Date

APR 3 - 2014

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Theodore J. Pernice,	)	
	)	
Petitioner,	)	
	)	
vs.	)	**No. 12 WC 43518**
	)	
Hill Mechanical,	)	
	)	**15IWCC0057**
Respondent.	)	
	)	

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

The parties agree that on September 27, 2012, the Petitioner and the Respondent were operating under the Illinois Worker's Compensation or Occupational Diseases Act and that their relationship was one of employee and employer. They agree that on that date Petitioner suffered accidental injuries or was last exposed to an occupational disease that arose out of and in the course of employment and that the Petitioner gave the Respondent notice of the accident which is the subject matter of the dispute within the time limits stated in the Act. They further agree that in the year preceding the injuries, the Petitioner's average weekly wage was $1,802.00, and that the Respondent has paid $3,776.59, in TTD payments.

At issue in this hearing is as follows: (1) Is the Petitioner's current condition of ill-being causally connected to this injury or exposure; (2) Were the medical services provided to the Petitioner reasonable and necessary and has Respondent paid for all reasonable and necessary medical services; (3) Is the Petitioner entitled to TTD from October 3, 2012 through October 10, 2013, or from October 8, 2012 through October 16, 2012 and November 8, 2012 through November 20, 2012; and (4) Is the Petitioner entitled to penalties and attorney fees under §§19(k), 19(l) and/or §16.

STATEMENT OF FACTS

Petitioner is a pipe fitter. He worked for respondent for approximately 7 years before the date of the accident which is the subject matter of the dispute. He was working for respondent as a pipefitter on September 27, 2012. He is a member of the pipefitters union. He has been a pipefitter for approximately 18 years. He has kept his union dues current.

Petitioner testified that he is 6'1" tall and at the hearing weighed 235 pounds. On the accident date, September 27, 2012 he weighed 220 pounds. Before the accident date he had no

complaints or problems with his left hip, had no problems with his back, had not sought medical treatment from any doctor for any complaints of the left leg, left hip, left side or his back.

The worked 8 to 10 hours a day five days a week for respondent. During the months before the date of the accident the work he performed for respondent was construction work consisting of lifting, climbing, welding, working on unpaved ground, cutting, going up and down ladders. He was able to do all of those jobs before the accident without complaints of pain in his left leg, left groin, left hip and back. He was required to climb ladders, climb up and down lifts, walk on pipe racks and climb towers. He used welding tools and a torch for cutting, chain vices, drills, hammer drills, and tools, and channel locks. His job required lifting four-inch pipe with four-inch pipe fittings and lifting up and carrying ladders. He would lift four-inch pipe weighing 280 pounds on the shoulders with the aid of one person.

On September 27, 2012 he started work for respondent at six o'clock in the morning at Ferrera Pan in Oak Park Illinois. He was assigned to pipe cooling units on the top of a building. He arrived at work between 5:15 and 5:20 AM and started work at 6:00 AM. At the start of the day he was fine and had no problems. After a break he was working on top of the units which had a siding similar to the aluminum siding on a house. There was Masonite laid on top of the siding so the siding would not get scratched. As he was walking on top of the Masonite he tripped at a point where two pieces of the Masonite were laying side-by-side. He tripped with his right foot and his whole body weight went forward. He caught himself with his left foot with impact on his left side. He felt immediate pain in his left hip. This happened between 10 o'clock and 11:00 AM.

Petitioner testified that the Masonite was 5' x 8' sheets about a quarter inch thick. The sheets of Masonite had been laid to protect the aluminum roof of the work site. Some of the sheets were connected with duct tape in some places and in others they were not. The accident happened as petitioner was walking back from his tool bucket where he had grabbed the laser. It was as he turned around and was starting to walk that he tripped. His right foot went underneath the Masonite at the joint. His left foot went forward and caught all of his weight of his body. He did not fall to the ground. He felt instant pain in his left groin area which he described as a sensation of being hot. Petitioner identified the area he was referring to as his groin as the area by the pocket of his jeans about half an inch to the left of his belt buckle, the point where the crease of his leg hits the trunk of his body. He stated that he had never felt pain in that groin area before. He described it as a sharp, dull, aching, stabbing pain.

Petitioner testified that being in the business he is in, he is constantly getting banged up and hurt but he would just carry-on and work through it. He tried to get through this pain and carry-on at work. Before lunchtime at approximately 11:30 he ran into his boss, Beth, and told her that he was hurt. He told her that he tripped and felt like he had a pretty bad pulled muscle in his groin or something. Beth was his immediate supervisor. He completed work that day and left at approximately 1:30 PM. His left groin was hurting. He went straight home. He put ice on it, took a shower. Next morning he awoke in pain. He thought it was a pulled muscle so he went to work. He arrived at work at 5:30 AM on Friday. He started work at 6:00 AM. He was hurting when he started work but he was able to finish work that day. He mentioned the pain to Beth again on that Friday. He called Judy from Medco, who was affiliated with insurance, by telephone. He explained to her what happened. She indicated it sounded like a pulled muscle

and directed him to get rest over the weekend and ice it. Petitioner followed her instruction. Petitioner took some pain medication he had in his house on Friday.

When he woke up on Saturday morning and sat on the couch he started to experience severe pain in the left hip and what he called nerve pains in the left and right quad. He continued to experience the same pain in the groin area that he had at the time of the accident. That pain was more intense. The pain in his quads was a sensation of his skin heating up. It was also a stabbing pain. The pain was in the upper quad and inner thigh of his left leg. On Sunday he took it easy.

On Monday he returned to work at Ferrera Pan and advised his supervisor of the pain he was experiencing. He was sent by respondent to the occupational safety health clinic. There he was seen by Dr. Khanna. After examination the doctor told him that he could return to work light duty. Petitioner called his supervisor, Ted, and was told to go home. Respondent provided petitioner with light duty work consisting of drilling holes in I-beams with a magnetic drill press. He was on his feet the whole time. He did not have to lift more than 20 pounds. At the end of the six hour day his left groin and leg felt bad pain as he was walking to his car at lunch his left leg went numb. He sat in his car at lunch for half-hour and advised his supervisor. Petitioner then made an appointment to see Dr. O'Laughlin.

The medical records and bill of Dr. Charles O'Laughlin/Alexian Brothers Medical Plaza were admitted in evidence as Petitioner's Exhibit Number 5. These records reveal that petitioner was examined by Dr. O'Laughlin on October 8, 2012. (PX 5, p9-10). Dr. O'Laughlin recorded a history of petitioner injuring himself at work on September 27, 2012 and based upon his physical examination of the Petitioner, his review of the petitioner's history, review of the x-rays of the lumbar spine which were interpreted to be normal and x-ray of both hips which were interpreted to be normal plus Dr. Laughlin noted petitioner had difficulty getting around. Dr. Laughlin suspected disc pathology with radiculopathy especially with the left lower leg possibly partially to the right lower leg as well. MRI of the lumbar spine and both hips were ordered to rule out pathology since he is having quite a bit of pain in the left hip area. Dr. O'Laughlin's diagnosis was suspected radiculopathy involving the left lower extremity possibly a high disc rupture. (PX 5, p9-10). Dr. O'Laughlin ordered petitioner off work on bed rest. (PX 5, pp. 10, 30).

MRI of the bilateral hips was performed on October 11, 2012, at Oak Brook Imaging. (PX 7, p 19). MRI of the lumbar spine without contrast was performed October 11, 2012 at Oak Brook Imaging. (PX 7, p 20). The MRI of the spine and hips was interpreted by Dr. Laughlin to show no evidence of a vascular necrosis or significant disc problem. Dr. O'Laughlin referred petitioner to a neurosurgeon. He noted that petitioner experiencing pain 5/10 which seems to be involving both legs where before it was just the left leg. (PX 5, p7-8). Petitioner was ordered off work. (PX 5, p 20).

On October 18, 2012, Dr. O'Laughlin notes petitioner called indicating that the insurance company wanted him to have a functional capacity evaluation. Dr. O'Laughlin noted that it was too soon to do this because he has not had a chance for healing to occur and would risk possibly worsening his condition. (PX 5, p 6).

On November 1, 2012, petitioner returned to Dr. O'Laughlin complaining of a lot of pain at the rate of 5/10 can't walk very far even 200 feet without a lot of pain; Dr. O'Laughlin noted

that a femoral nerve stretch test gives him trouble both in the front of the thigh and along the hip area. He noted this could represent a nerve irritation or ruptured disc or muscle pull, certainly not specific. Petitioner was also having pain in the right thigh. Dr. O'Laughlin referred him to see a neurologist. Dr. O'Laughlin noted the diagnosis is presumed lumbar radiculopathy. (PX 5, p4-5). Dr. O'Laughlin ordered petitioner remain off work. (PX 5, p 19).

On November 8, 2012 petitioner was examined by Dr. G.G.Glista of Medical Neurology Associates, S. C. whose medical records were admitted in evidence as Petitioner's Exhibit 7 and Exhibit 8. After history of onset of the pain in the anterior aspect of the left iliac crest area of the left hip Dr. Glista conducted examination. Dr. Glista noted that he concurred with all the other physicians that this was musculoskeletal; he has been six weeks off work and unfortunately hasn't improved much; he should get a physical therapy evaluation. Dr. Glista noted that he told petitioner he had no evidence that there was a permanent neurological or musculoskeletal damage and that this should heal. He noted that he would return in two weeks and put him on light duty for a week or two and then get him back to full duty. (PX 7, p 6-8).

On November 20, 2012 petitioner returned to Dr. Glista. He noted that petitioner complains that the pain; has not improved and has gotten worse; Pain was now in both hips, pain in the back and down his legs with numbness ; he's gotten very anxious; almost became tearful; and got a bit agitated when I told him that I really had found nothing alarming and couldn't explain that for two months he has been so functionally disabled and off work; also the fact that I gave him a low dose course of steroids and there was no improvement whatsoever in his symptoms. Dr. Glista noted that he had a little talk with petitioner in a way to prove to him that there is most probably no nerve injury of any sort that he could identify or clinically correlate with his complaints, how they evolved and became so diffuse and disabling months after a relatively trivial injury that was described in the original consultation. No medication was ordered by Dr. Glista because he was not sure that anything was going to help them in an objective fashion. (PX 7, p 4-5).

On November 28, 2012 Dr. Glista noted that he had met with a nurse in his office to discuss petitioner. Dr. Glista noted to the nurse that the last time that he saw petitioner he told him directly that he could offer no neurological explanation for his disability. Dr. Glista noted that he thought it was not unreasonable since he's been off work more than two months and extensive testing was negative that petitioner should at least consider returning to some form of light duty. Dr. Glista noted at this point he had no other therapeutic or diagnostic recommendations and released petitioner to light duty. (PX 8, p 4-5).

On November 30, 2012 Dr. O'Laughlin noted that petitioner had called to report that he has a lot of pain in the leg and elsewhere. He was asking what he should do. He had an EMG with Dr. Glista that was normal. Dr. O'Laughlin noted that petitioner was upset with Dr. Glista in terms of the treatment and frustrated with the whole process of his condition. (PX 5, p 4).

When petitioner was released by Dr. Glista he sought treatment with another neurologist, Dr. Scott Lipson. The medical records of Dr. Lipson/Neurology Consultants, S.C. were admitted in evidence as Petitioner's Exhibit Number 10. Dr. Lipson examined petitioner on December 12, 2012, noting history of tripped on a piece of Masonite with sudden onset of left hip pain which has persisted ever since. No prior history of pain in the back or hip before the accident. After review of the tests Dr. Lipson noted that he was suspicious that his cause of pain is not

neurological and recommended an orthopedic opinion and pain medicine evaluation and treatment and ordered MRI of the lumbar spine. (PX 10, p7-9). MRI was performed on January 2, 2013, at SKAN and was interpreted to show no acute or advanced findings. (PX 10, p 5).

The Petitioner testified that Dr. Lipson referred him to a pain specialist, Dr. Intesar Hussain. The medical records of Dr. Hussein/The Pain Center of Illinois were admitted in evidence as Petitioner's Exhibit Number 12. These records reveal petitioner was examined by Dr. Hussein on December 13, 2012, with history of three-month history of left hip pain and low back pain that is intermittent. (PX 12, p 20). After examination and review of diagnostic tests Dr. Hussein made assessment of left hip pain, the etiology of which is currently unclear; internal derangement of the left hip capsule is suspected; suspect the patient has some intermittent lower back pain that may be related to facet arthroplasty but the pain here seems to be coming from the left hip. Dr. Hussein ordered MRI arthogram of the left hip or MRI of the left hip with contrast to rule out labral tear. (PX 12, p 22).

On December 17, 2012, petitioner returned to Dr. Hussein complaining of pain in the anterior left hip and side of the hip, feels popping in the hip with certain movements, pain is sharp and achy in nature worse with activity better with rest. Dr. Hussein referred petitioner for an orthopedic evaluation. (PX 12, p 18).

On December 20, 2012, petitioner was examined by Dr. Kevin Tu of G&T Orthopedics and Sports Medicine whose medical records were admitted in evidence as Petitioner's Exhibit Number 11. After examination and review of diagnostic testing Dr.Tu's impression was left hip labral tear and ordered MRI arthogram of the left hip. He ordered petitioner to continue work at his current restriction level. (PX 11, p 11).

MRI arthogram of the left hip was performed at Skan on January 4, 2013. The MRI arthogram was interpreted to show labrum is intact; no fracture or dislocation. (PX 12, p 24-25).

Petitioner returned to Dr. Hussein on January 7, 2013. Physical exam was unchanged. Assessment was left hip pain, labral tear not ruled out by diagnostic imaging. Physical therapy was ordered for the left hip Norco and Flexeril medication orders were continued. Follow-up appointment with Dr. Tu was ordered. (PX 12, p 16-17).

On January 10, 2013, petitioner was examined by Dr.Tu. After review of the MRI arthogram his impression was left hip labral tear. He noted that imaging studies did not confirm labral tear, however, he does have symptoms consistent with labral tear. He recommended diagnostic intra-articular injection to the left hip. Current restriction level work was ordered. (PX 11, p 18).

On February 7, 2013, Petitioner returned to Dr. Hussein after having seen Dr. Tu who requested a left hip injection. Dr. Hussein administered left hip injection on that date. (PX 12, p 14-15). That injection was performed at the Grand Avenue Surgical Center whose records were admitted in evidence as Petitioner's Exhibit Number 13.

On February 18, 2013, petitioner returned to Dr. Hussein who noted that petitioner said he had 50% relief of pain from the injection. Dr. Hussein referred petitioner back to Dr.Tu to determine whether or not petitioner is a candidate for a left hip arthroscopy. Medication orders and physical therapy were continued. Dr. Hussein noted that the Petitioner requested a work

status and so he ordered petitioner off work until his evaluation with Dr. Tu. Petitioner was to return two weeks after obtaining Dr. Tu's input. (PX 12, p 12-13).

On February 21, 2013 petitioner was seen by Dr.Tu who noted that petitioner had temporary improvement of his symptoms after Cortisone injection in the left hip joint. Dr.Tu noted that he continued to have symptoms despite conservative treatment, that he had improvement after an intra-articular injection would indicate pathology in the left hip joint. He was referred by Dr. Tu to an orthopedic hip specialist for possible arthroscopy. Petitioner was ordered off work. (PX 11, p 26).

Petitioner testified he was referred to Dr. Gregory Primus by Dr.Tu. The medical records of Dr. Gregory Primus/Chicago Sports Orthopedics were admitted in evidence as Petitioner's Exhibit Number 14. These records reveal petitioner was examined by Dr. Primus on March 8, 2013. (PX 14, p 18). After history examination and review of diagnostic tests Dr. Primus assessment was hip pain, pelvis sprain, OA of the hip, counseling, and he recommended surgery, arthroscopy. (PX 14, p 18-20).

On April 8, 2013 petitioner returned to Dr. Hussein who noted that petitioner had seen Dr. Primus, hip specialist and was diagnosed with a cam lesion of the left hip and had been recommended for surgery. Petitioner continues to take pain medication for his left hip pain. Dr. Hussein ordered continued prescription pain medication and follow-up with Dr. Primus as needed for surgery. (PX 12, p 10-11).

Petitioner returned to Dr. Primus on July 5, 2013, for preoperative consultation of the left hip pain. Dr. Primus noted that the symptoms are worse since the last visit. (PX 14, p 14). Recommendations remained arthroscopic surgery. Prescriptions were ordered. (PX 14, p 16).

On July 15, 2013, Dr. Primus performed surgery on petitioner at the Lakeshore Surgery Center consisting of: (1) left hip arthroscopic extensive debridement with removal of acetabular pincer lesion; (2) Labral repair; (3) Cam lesion removal with femoroplasty. Postoperative diagnosis was: (1) left hip femoral acetabular impingement; (2) labral tear. (PX 14, p 161).

On July 26, 2013, petitioner was seen by Dr. Primus for follow-up after surgery on his left hip. He noted that symptoms have improved since his last visit. He noted that his back pain is completely resolved since the surgery. (PX 14, p 12).

On August 2, 2013, petitioner was examined by Dr. Primus. Dr. Primus noted that the incision has become inflamed. Wound debridement was performed. Antibiotic ointment was applied. Norco and other medications were ordered. (PX 14, p9-10).

On August 23, 2013, petitioner was seen by Dr. Primus again for follow-up. The incision seemed to be healing. When walking on crutches Petitioner reported that he feels as though the hip is popping in and out. Medications were ordered and physical therapy was ordered. (PX 14, p 7-8.)

Petitioner testified that after the surgery the sharp shooting pain was gone. He could get comfortable rather than being uncomfortable all day. At the hearing petitioner noted he was six weeks off of crutches and two and half months out of surgery. He has some pain but he was happy. He had an appointment to see Dr. Primus for further follow-up in five weeks. Petitioner

identified Petitioner's Exhibit Number 19 as an off work job status report dated October 4, 2013, from Dr. Primus ordering that he be off work. Petitioner has remained off work since his last day of work which was when he worked the drill press and couldn't finish work that day. He has worked nowhere else since that date. Petitioner was in the course of physical therapy, at the time of the hearing, at Total Rehab at the Elmhurst Memorial clinic.

Petitioner testified that he had received a request to come back to work by respondent after the IME examination but that Dr. O'Laughlin had ordered him off work and he followed his doctor's direction and did not return to work.

He keeps his union dues current and they were current at hearing. The prescription medication he took immediately after the accident was left over from a foot problem he had five years earlier.

The pain radiating in his left leg was in the thigh and once in a great while would go down to his calf. The real concern was the thigh, the hip and a butt cheek and the lower back into the right. When he saw Dr. O'Laughlin on October 8, 2012, he was having pain in addition to the left side on the right side back pain. When he saw Dr. Glista on the 20th he was getting worse and was having pain in both his hips and back and legs. Dr. Glista told him to go back to work on November 28, 2012.

Petitioner testified during the course of the treatment of the work accident he had problems with his penis and could not get an erection. He could not urinate in a steady stream. Dr. O'Laughlin was concerned about this and that is why he sent him to a nerve doctor, Dr. Glista.

Petitioner testified since the surgery the nerve pain has greatly subsided. Petitioner testified that the entire time he saw Dr. Hussein he continued petitioner off work while he was trying to figure out what was going on. Petitioner testified Dr.Tu also gave him off work notes. Although no notes were provided in the medical records of Dr. Tu, there is a notation in the February 21, 2013, medical records of Dr. Tu noting Petitioner is to remain off of work. (PX 11, p.26)

Dr. Gregory Primus testified by evidence deposition admitted in evidence as Petitioner's Exhibit number 1. He is a physician licensed in the state of Illinois board-certified in orthopedics. (PX 1, p. 4-5). He is on the staff of advocate hospital systems, Metro South, Mercy Hospital, and St. Anthony's. (PX 1, p. 4). After his initial examination of petitioner his impression was a femoral acetabular impingement with cam lesion with cystic changes and a smaller pincer lesion along the acetabular rim. (PX 1, p. 10). Dr. Primus opined that the bony morphology which is the cam and the pincer lesion could have been pre-existing, a part of his normal body morphology. He did opine with a reasonable degree of orthopedic and medical certainty that petitioner's hip condition became symptomatic due to petitioner's traumatic incident at work and was related to his work injury on September 27, 2012. (PX 1, p. 12). Dr. Primus stated that the mechanism of injury as the patient described it and as reflected in his records was consistent with causing this pre-existing condition to become symptomatic. (PX 1, p 12-13). Dr. Primus explained that it is well documented in the literature that femoral acetabular impingement is normally caused by some increased torque or twisting movement on the hip joint. It can be exacerbated with prolonged hip flexion and extension. Petitioner's traumatic

incident was well within the mechanism of injury patterns where we see these types of injuries take place. (PX 1, p 13). Dr. Primus testified that the condition which he diagnosed in petitioner is such that it can be confused with other types of causes, specifically spinal issues and other potential problems. He testified that:

> the hip joint itself is a very deep structure inside the pelvis. The nerves that pass by the joint and innervate the capsule and surrounding tissues are also part of a nerve pathway that mimics spinal disease, and so we find that people that have hip joint pain may have radiating anterior thigh pain and radiating medial cited thigh pain all the way down to the medial knee. In fact, it's been documented that people with intra-articular hip pathology may only present with medial sided the pain simply because of the nerve distribution. (PX 1, p. 13-14)

Dr. Primus commented that what is interesting about the intra-articular hip pathology and that this has been well documented in the literature is that early on in our understanding the average time to diagnosis was seven to eight months. He continued with his explanation saying:

> that "oftentimes with men, they underwent unnecessary spinal surgeries trying to address this intra-articular hip pain because it was thought that it was related to the spine, and for women, the underwent multiple, at times, unindicated gynecologic procedures to address this pelvic pain that had remained elusive. (PX 1, p. 14)

Dr. Primus testified this has all been well-documented and petitioner's story is quite classic in terms of how these intra-articular hip diagnoses were originally diagnosed. (PX 1, p 14-15).

Dr. Primus testified that the most pertinent finding and examination will be pain with limited internal rotation especially with an axial load with the hip flexed. He testified that there can be a relatively normal range of motion with this condition. (PX 1, p 16). Dr. Primus testified that the fact that petitioner got significant relief of the complaints of left groin and left leg pain when he was administered epidural steroid injection into the left hip was a significant diagnostic tool in confirming the diagnosis. (PX 1, p 17).

Dr. Primus testified that when he performed surgery and examined the joint it was consistent with his expectation and his recommendation for surgery. (PX 1, p. 20). Dr. Primus testified that the labral tear was caused by the fall at work. (PX 1, p 20-21). Dr. Primus testified that from the first time he saw petitioner his condition was such that it limited his ability to return to work in his normal capacity. After the surgery was performed the condition requires petitioner to be off work as part of the routine postoperative care. (PX 1, p. 23). Physical therapy is ordered as a necessary part of the postoperative treatment. (PX 1, p. 24).

Dr. Primus said that the petitioner's complaints of urological problems could have been a distinct entity having nothing to do with the intra-articular hip pathology. (PX 1, p. 25). According to Dr. Primus, the most telling symptom of femoral acetabular impingement syndrome is groin pain. (PX 1, p. 28-29). When questioned about what specifically was attributable to the cause of Petitioner's pain, Dr. Primus testified that "any twist or torque at the hip joint which also can be in association with impact loading so if you are standing and you slip or you catch yourself so you're impacting there is an action stress on the hip joint with a twist or torque and those are very reasonable actions that can lead to injury of the hip and lead to intra-

articular pathology." (PX 1, p. 29). In the surgery Dr. Primus found a labral tear and given the fact that he did not complain of hip pain prior to the incident it's very reasonable to conclude that the incident led to the labral tear and the symptoms that ultimately presented to him seeking treatment. (PX 1, p. 29-30).

Dr. Primus testified it is possible to have a labral tear with no symptoms. Dr. Primus testified that the mechanism of injury, the fact that he was not being treated for hip or groin symptoms prior to the injury, imaging studies that occurred subsequent, the treatment that occurred subsequent, his response to the treatment, and the pathologic findings that he found during the diagnostic arthroscopy led him to the conclusion that it's reasonable that the inciting event that led to his symptoms was the incident at work. (PX 1, p. 32). The immediate onset of pain with the incident was also a factor which played a role in formulating his opinion that the work accident caused the condition. (PX 1, p 35-36).

Dr. Mark N. Levin testified by evidence deposition admitted in evidence as Respondents Exhibit Number 15. He is a physician licensed to practice medicine in the State of Illinois, board certified in orthopedic surgery. He examined petitioner on October 16, 2012, and again on December 11, 2012, at the request of respondent pursuant to Section 12 of the Act. He took a history and reviewed x-rays, MRI studies and diagnosed a subjective left groin strain. He testified that when he saw petitioner on December 11, 2012, his subjective complaints of pain were out of proportion to objective findings. (RX 15 p. 18) Dr. Levin testified he was not able to substantiate the mechanism of injury with the subjective findings. (RX 15 p. 18). He testified that after he reviewed the MRI films he would expect petitioner to have femoral acetabular impingement on the right but not on the left. (RX 15 p. 20).

Dr. Levin concluded that from an orthopedic standpoint there was no objective orthopedic pathology that requires further treatment, he could not relate the need for any further treatment and could find no reason why the Petitioner could not return to work full duty. (RX 15 p. 19)

CONCLUSIONS OF LAW

The burden is upon the party seeking an award to prove by a preponderance of the credible evidence the elements of his claim. *Peoria County Nursing Home v. Industrial Comm'n*, 115 Ill.2d 524, 505 N.E.2d 1026 (1987). This includes the nature and extent of the petitioner's injury.

The burden of proving disablement and the right to temporary total disability benefits lies with the Petitioner who must show this entitlement by a preponderance of the evidence. *J.M. Jones Co. v. Industrial Commission,* 71 Ill.2d 368, 375 N.E.2d 1306 (1978)

It is not enough Petitioner is working when accidental injuries are realized; Petitioner must show the injury was due to some cause connected with employment. *Board of Trustees of the University of Illinois v. Industrial Commission,* 44 Ill.2d 207.

Is the Petitioner's current condition of ill-being causally connected to this injury or exposure?

The evidence in this record demonstrates that petitioner had no complaints regarding pain in his left leg, left groin or low back prior to the date of the work accident on September 27, 2012. The onset of pain in the groin with the accident was immediate according to the testimony of the Petitioner.

Petitioner described his work activities as a pipefitter as heavy construction consisting of lifting, climbing, welding, working on unpaved ground, cutting using a blowtorch, climbing up and down lifts, walking on pipe racks in the air and climbing towers. He described the work as strenuous and vigorous. He sometimes carried pipe that was 21 feet long with the aid of one other coworker. He used drilling and cutting tools and climbed ladders to do overhead pipe work. He was able to do all of these tasks without complaints of left hip, left groin, left leg or back pain prior to the work accident. There is no indication that petitioner injured his left groin, left leg or back in any other accident after the work accident of September 27, 2012. The Petitioner's symptoms have been constant from the date of the accident up to the date of surgery and through the date of hearing.

Dr. Primus, a board-certified orthopedic surgeon, testified that in his opinion petitioners work accident of September 27, 2012, was the cause of the symptoms which brought petitioner to seek medical treatment from the medical providers identified in the record and which were ultimately diagnosed by Dr. Primus as left hip femoral acetabular impingement and labral tear leading to arthroscopic surgery of the left hip performed by Dr. Primus on July 15, 2013.

Dr. Primus testified that femoral acetabular impingement is documented in the medical literature to present symptoms complicating the correct diagnosis, as was the case here. Moreover, Dr. Primus performed arthroscopic surgery on petitioner and testified that his examination of the hip joint during that surgery confirmed his diagnosis. He testified that the mechanism of injury described by petitioner was consistent with the onset of the symptoms as the cause of the femoral acetabular impingement.

Respondent's Section 12 examining physician Dr. Mark Levin, opined after two examinations of petitioner that his condition was a groin strain and that he was exaggerating his symptoms. Dr. Levin testified that he could not find any objective pathology that required further treatment, and if he were going to diagnose femoral acetabular impingement in the Petitioner it would be in the right hip, not the left. Dr. Levin's opinion is inconsistent with the findings at surgery of acetabular impingement of the left hip. Petitioner was never diagnosed with a groin strain. Dr. Primus testified that pain in the groin is one of the symptoms of femoral acetabular impingement. The arbitrator finds that Dr. Primus opinions are more credible than the opinions of Dr. Levin and supported by the findings at the time of the surgery. Based upon the totality of the evidence in this record, the arbitrator finds that petitioner's current condition of ill being of the left hip is causally related to the work accident of September 27, 2012.

Were the Medical Services That Were Provided to Petitioner Reasonable and Necessary? Has Respondent Paid All Appropriate Charges for All Reasonable and Necessary Medical Services?

Dr. Primus testified that in his opinion all of the treatment petitioner received in attempting to come to the correct diagnosis of petitioner's condition of ill being was reasonable and necessary. Dr. Levin testified that it was not reasonable or necessary; the Petitioner had a groin strain, not femoral acetabular impingement. Dr. Levin, in hindsight, was wrong.

Having found that petitioner's femoral acetabular impingement is causally related to the work accident, the arbitrator finds that the treatment Petitioner received in eventually arriving at a diagnosis and treatment was reasonable and necessary and Respondent is responsible for paying for the treatment, subject to the fee schedule or previous agreement, whichever is less. Respondent shall pay all of the medical bills identified in the list attached to the request for hearing as Arbitrator's Exhibit Number 1.

Is the Petitioner entitled to TTD from October 3, 2012 through October 10, 2013, or from October 8, 2012 through October 16, 2012 and November 8, 2012 through November 20, 2012?

Petitioner was ordered light duty work by Dr. Khanna of the respondent's occupational clinics. Light duty work was provided to petitioner consisting of drilling holes in beams. The evidence indicates petitioner attempted to do the light duty work but his pain increased so that he was unable to continue in light duty.

Petitioner was ordered off work by Dr. O'Laughlin beginning October 8, 2012. PX 5, p 30. Off work orders were continued by Dr. O'Laughlin and petitioner's subsequent treating physicians until the Petitioner saw Dr. Glista who on November 28, 2012, returned the Petitioner to work with restrictions. Petitioner did not attempt to return to work, was not being treated by Dr. O'Laughlin and so he should have at least attempted to return at that time.

The next record of the Petitioner being taken off of work by a treating physician is in the medical records of Dr. Hussein on February 18, 2013, who took him off of work until he saw Dr. Tu. On February 21, 2013, Dr. Tu continued the Petitioner off of work.

Dr. Primus testified that petitioner remains off work at the time of hearing as result of the left hip arthroscopy which he performed. The arbitrator finds that petitioner is entitled to TTD from October 3, 2012 to November 28, 2012 and again from February 18, 2013 through the time of the hearing, October 10, 2013 and respondent is ordered to pay TTD for those periods.

Petitioner stipulated that respondent has paid $3776.59 in TTD to the date of hearing; the Respondent shall receive credit for any TTD that has been previously paid.

Is the Petitioner entitled to penalties and attorney fees under §§19(k), 19(l) and/or §16.

Petitioner filed a petition for penalties and attorney's fees under section 19(k), 19(l) and 16 of the act. Petitioner claims that the Respondent had no reasonable basis to deny medical

treatment or TTD and that the conduct was unreasonable, vexatious and intended to delay benefits due to the Petitioner.

The Petitioner saw six doctors (Khanna, O'Laughlin, Glista, Lipson, Hussain and Tu) before he got to Dr. Primus who finally figured out what was causing his pain. Three of the doctors thought that the Petitioner could work while he was being diagnosed and treated, with restrictions. The Petitioner did not attempt to go back to work after the first time with Dr. Khanna. He should have given his employer the opportunity to see if the restrictions could be accommodated, and he should have tried to at least return. Absent information that he could not work under the conditions, or that the respondent could not accommodate the restrictions, the Respondent is not entirely at fault with respect to the nonpayment of TTD. Also, no off work slips were provided in evidence from Dr. Hussein when he took Petitioner back off of work after Dr. Glista returned him to work the second time.

Six doctors tried to figure out what was wrong and failed. Dr. Levin examined the Petitioner twice and he like some of the Petitioner's treating doctors thought the Petitioner could work. He gave a medical opinion that he felt the injury was a groin strain. It was only after the surgery that the opinion was proved wrong. The Respondent reasonably relied on the opinion of a board certified orthopedic surgeon, whose opinion was similar to the doctors who came before Dr. Primus.

The arbitrator finds based upon the weight of evidence in this record that Respondent had a reasonable basis to deny medical treatment and TTD due Petitioner. The fact that it was wrong does not make it unreasonable. The Arbitrator finds that under the facts of this case, the Respondent's conduct was not unreasonable, vexatious, and intended to delay benefits due petitioner.

The Petitioner's petition for penalties and fees is denied.

ORDER OF THE ARBITRATOR

Respondent shall pay Petitioner temporary total disability benefits of $1,201.97 / week for 20 3/7 weeks commencing October 18, 2012 through November 28, 2012, (6 weeks) and February 18, 2013 through October 10, 2013,(33 5/7 weeks) a total 39 5/7 weeks, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical expenses with respect to the testing and treatment that Petitioner received for his lower back and leg, hip and groin, pursuant to the medical fee schedule or by prior agreement, whichever is less, pursuant to the Act.

Respondent shall be given credit for $3,776.59 for TTD that has been previously paid.

Petitioner's request for attorney's fees and penalties is denied.

Deborah L. Simpson
Signature of Arbitrator

April 1, 2014
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)
☒ Modify	☐ PTD/Fatal denied
	☐ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Gina Catalanello,

Petitioner,

vs.

NO: 04 WC 45978

Horizon House of IV, Inc.,

15IWCC0058

Respondent,

DECISION AND OPINION ON REVIEW

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

So that the record is clear, and there is no mistake as to the intentions or actions of this Commission, we have considered the record in its entirety. We have reviewed the facts of the matter, both from a legal and a medical / legal perspective. We have considered all of the testimony, exhibits, pleadings and arguments submitted by the Petitioner and the Respondent and find that Petitioner suffered an intervening incident on March 20, 2007, which terminates Respondent's liability and requirement to pay compensation after that date.

The Commission notes that Petitioner was attacked by her boyfriend on March 20, 2007. (T.47-48) Petitioner testified that she was beaten by her boyfriend and explained that he beat her with his fists about the head, arm and back. (T.47-48) Petitioner's testimony is consistent with the history taken at the emergency room. (PX3) The nurse noted that Petitioner was assaulted by her boyfriend and that he "beat" her. (PX3) The emergency room nurse further noted that noted that the beating took place while Petitioner and her boyfriend were "in [a] car at stop sign." The nurse's note explains that Petitioner was dragged out of the car by her boyfriend and into his

aunt's home, where he continued to beat her. The emergency room medical report noted that Petitioner had "[b]ruising to [right] arm, [left] forearm, [left] [illegible], [left upper] back. Large area of swelling to [left upper] back. [left] eye bruised and swollen." (RX5)

Petitioner returned to the emergency room complaining of severe head and neck pain on April 2, 2007. (T.48,RX6) She was diagnosed with a subdural hematoma and underwent a right frontal temporoparietal craniotomy for evacuation of hematoma. (RX6)

In a letter dated August 21, 2009, and addressed To Whom It May Concern, Dr. Perales indicated that the March 20, 2007 attack caused Petitioner "multiple injuries, including: subdural hemorrhaging of the brain, chronic pain syndrome, loss of balance, memory loss, and chronic headaches." (PX3) Dr. Perales explained that since undergoing a right frontal temporoparietal craniotomy for evacuation of a hematoma on April 7, 2007, Petitioner "has had memory loss and loss of balance. After the attack she suffered from severe anxiety disorder. I am treating her chronic pain with narcotics: Roxycodone and Oxycontin. Her anxiety disorder is being treated with Xanax. [Petitioner] is totally disabled." (PX3)

The Commission notes that while Petitioner was still suffering from back pain and sciatica prior to the March 20, 2007 accident, Petitioner did not require any surgical intervention for her lumbar problems until after the March 20, 2007 attack. The medical records from Dr. Perales show that Petitioner's lumbar problems worsened following the March 20, 2007 attack. Finally, the Commission notes that in his August 21, 2009 letter, Dr. Perales attributes Petitioner's ongoing issues to the March 20, 2007 attack and finds that Petitioner is totally disabled following the March 20, 2007 attack. Nowhere does he ascribe Petitioner's inability to work to her work accident.

Therefore, based upon the totality of the evidence, the Commission finds that the March 20, 2007 attack constitutes an intervening act, breaking the causal connection between Petitioner's current conditions of ill-being and the March 4, 2004 work accident. As such, the Arbitrator's award of partial temporary disability benefits commencing on April 12, 2010 is hereby vacated.

The Commission further notes that Petitioner underwent a considerable amount of conservative treatment following the March 4, 2004 work accident and up to the March 20, 2007 intervening attack. Petitioner was still suffering from lumbar back problems as a result of the March 4, 2004 attack which were worsened by the March 20, 2007 attack. Therefore, based on the totality of the evidence, the Commission finds that Petitioner has suffered a 10% loss use of the person as a whole as a result of the March 4, 2004 attack.

One should not and cannot presume that we have failed to review any of the record made below. Though our view of the record may or may not be different than the arbitrator's, it should not be presumed that we have failed to consider any evidence taken below. Our review of this material is statutorily mandated and we assert that this has been completed.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's Decision is modified as stated above, and is otherwise affirmed and adopted.

15IWCC0058

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $200.83 per week for a period of 4-2/7 weeks, that being the period of temporary total incapacity for work under Section 8(b) of the Act. Respondent shall be given credit for all sums previously paid hereunder.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner $36,813.28 in medical expenses as provided under Sections 8(a) and 8.2 of the Act. Respondent shall be given credit for medical benefits that have been paid.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay Petitioner permanent partial disability benefits of $382.40 per week for a further period of 50 weeks, as provided in Section 8(d)2 of the Act, because the injury sustained caused a 10% loss of use of the person as a whole.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $36,900.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JAN 2 3 2015
MJB/ell
o-12/02/14
52

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

CATALANELLO, GINA
Employee/Petitioner

Case# **04WC045978**

HORIZON HOUSE OF IV INC
Employer/Respondent

15IWCC0058

On 1/30/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.06% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0400 LOUIS E OLIVERO & ASSOC
DAVID W OLIVERO
1615 FOURTH ST
PERU, IL 61354

0445 RODDY LEAHY GUILL & ZIMA LTD
ROBERT J DOHERTY JR ESQ
303 W MADISON ST SUITE 1500
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF LASALLE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
CORRECTED ARBITRATION DECISION

GINA CATALANELLO,
Employee/Petitioner

v.

HORIZON HOUSE OF IV, INC.,
Employer/Respondent

Case # 04 WC 45978

Consolidated cases: _____

15IWCC0058

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **George Andros**, Arbitrator of the Commission, in the city of **New Lenox on 10/10/12 and** , on **07/23/13**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **03/04/04**, 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 **$15,664.68**; the average weekly wage was **$301.24**.

On the date of accident, Petitioner was **39** 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 **$631.18** for TTD, $ 0 for TPD, $ 0 for maintenance, and $ 0 for other benefits, for a total credit of **$631.18**.

Respondent is entitled to a credit of $2,200.03 under Section 8(j) of the Act.

CORRECTED ORDER

Respondent shall pay petitioner temporary total disability benefits of $200.83/week for **4&2/7 wks**, commencing 03/05/04 through 03/18/04 and 07/22/04 through 08/06/04, as provided in Section 8(b) of the Act. Respondent to receive credit for all sums previously paid hereunder.

Respondent shall pay reasonable and necessary medical services of $96,691.98, as provided in Section 8(a) of the Act and pursuant to the medical fee schedule. Respondent to receive credit for all sums previously paid hereunder.

Respondent shall pay petitioner permanent totally disability benefits of $382.40/ week for life, commencing 04/12/10, as provided in Section 8(f) of the Act.

Commending on the second July 15th after the entry of this award, petitioner may become eligible for cost-of-living adjustments paid 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.

#5, George S. Andros

CORRECTED AWARD –ARB ANDROS

Signature of Arbitrator

JAN. 28, 2014

Date

JAN 30 2014

PRELUDE & CASE OVERVIEW 04 WC 45978

This case is determined by the preponderance of the medical opinions of many doctors, all of whom practice in central Illinois in their well defined practice areas. The hub of the referrals of treatment was Dr. Constantino Perales. He referred the Petitioner to the Associated University Neurosurgeons at the medical complex in Peoria. Both Dr. William Olivero and his colleague, Dr. Dinh evaluated the patient. That evaluation included consult with Dr. Lisa Snyder and return to Dr. Dinh Dr. Snyder discussed management of her chronic pain. Dr. Dinh relied upon in part the discogram from St. Francis Medical Center in Peoria plus MRI. That discogram demonstrated a grade 4 tear pattern at L4-L5 level. Later discogram and differing opinions between Dr. George De Phillips and section 12 examiner Dr. Steven Delheimer were manifested in the evidence. The Arbitrator finds that despite the defense' tenacious efforts to underscore this worker's domestic physical abuse and likely over medicating at times as breaking the chain of causation, the Arbitrator in a close call by a preponderance of the evidence adopts the opinions and direction of the case and medical conclusions over the years espoused by Drs.Perales, Oliverio, Dinh and , in this specific case, Dr. George De Phillips. This person became downtrodden and even hopeless over the years and at times relying heavily on her only available form of treatment namely medication - given surgical and or invasive remediation were not granted under workers compensation benefits via primarily Dr. Delheimer.

STATEMENT OF FACTS 04 WC 45978

At Arbitration, employee, GINA CATALANELLO, testified that she began working for employer, HORIZON HOUSE OF IV, INC., in September 1999, teaching disabled adults basic day-to-day skills. Employee CATALANELLO worked for employer, HORIZON HOUSE OF IV, INC., continuously until November 2006 when she was involuntarily let go. Employee CATALANELLO also testified that she never had any injury to her low back before working for employer, HORIZON HOUSE OF IV, INC., nor had she ever received any medical treatment to her low back.

On March 4, 2004, employee CATALANELLO was leaning over a bathtub to assist a disabled adult, when she was unexpectedly physically assaulted by another resident who came up from behind and began punching and kicking her in the low back area. Following the attack, employee CATALANELLO had to seek immediate medical attention since she could not straighten up her back and had numbness in her right buttock area.

ILLINOIS VALLEY COMMUNITY HOSPITAL - EMERGENCY ROOM

On March 4, 2004, at 9:00 p.m., employee CATALANELLO arrived at the emergency room of Illinois Valley Community Hospital complaining of having low back pain and right hip pain from being punched and kicked in that area. The emergency room records verify that she was experiencing significant low back pain and was unable to straighten all the way. An emergency room physician examined her and ordered pelvic x-rays, which did not reveal any fracture.

He diagnosed employee CATALANELLO with trauma to the right lower back and iliac crest and instructed her to rest, use an ice pack on her low back, take Vicodin for pain and follow up the next day for further treatment in the Occupational Health Department at Illinois Valley Community Hospital.

ILLINOIS VALLEY COMMUNITY HOSPITAL - OCCUPATIONAL HEALTH DEPT.

On March 5, 2004, employee CATALANELLO went to the Occupational Health Department and informed the therapist that she was still experiencing low back pain, especially when bending. The therapist noted in the chart that employee CATALANELLO was slow getting up from a chair and that her gait was guarded. The therapist found on examination, tenderness in employee CATALANELLO's back, which she treated with ice and heat and range of motion exercises. After one physical therapy session, the Occupational Health Department discharged employee CATALANELLO back to regular duty.

On March 10, 2004, employee CATALANELLO returned to Occupational Health Department because she could not work due to the pain in her low back area. Dr. Fesco, the Occupational Health physician, drew a diagram in his chart showing the location of her low back pain, muscle spasm, a hematoma and the radiation of the pain. Dr. Fesco's diagnosis was that employee CATALANELLO had an acute lumbo-sacral muscle spasm and ecchymosis. He recommended further physical therapy, Flexeril for her muscle spasm and restricted her from all work.

On March 15, 2004, employee CATALANELLO returned to Dr. Fesco and reported that she was feeling much better and was not experiencing pain in the thigh or night time pain. Dr. Fesco's impression was that her lumbo-sacral sprain was resolving and that she could return to work with a 15 pound restriction. Since her employer could not accommodate these restrictions, she stayed off work.

On March 17, 2004, employee CATALANELLO received physical therapy for her low back and the therapist's chart note reflected that employee CATALANELLO still rated her pain as a 5 out of 10, which after the therapy session reduced to a 3 out of 10.

On March 18, 2004, Dr. Fesco examined employee CATALANELLO and did not find any muscle spasms or leg pain, so he then released her to return to full-duty work.

Employee CATALANELLO testified that following her return to work, she still experienced quite a bit of lower back pain and stiffness in her back and could not fully perform her job. Employer, HORIZON HOUSE OF IV, INC., accommodated her limitations by assigning her to a van driver's position. Over the course of the next two months while on light duty, employee CATALANELLO was still having problems with her low back.

DR. CONSTANTINO PERALES

On July 1, 2004, employee CATALANELLO sought further medical attention for her low back pain from Dr. Constantino Perales, a physician she had never seen before but one who had treated her son. Employee CATALANELLO gave Dr. Perales a history of having injured her back at work in March and was still having cramps in the low back with leg pain, right worse than left, and stiffness. Dr. Perales examined her back and found tenderness, a positive straight leg raising and positive deep tendon reflexes. Dr. Perales diagnosed her with low back pain, prescribed a lumbar support for her to use at work and ordered a lumbar MRI. On July 8, 2004, employee CATALANELLO had a lumbar MRI at Illinois Valley Community Hospital, which the radiologist interpreted as showing a broad-based L4-5 disc protrusion with annular tear.

On July 22, 2004, employee CATALANELLO had a follow-up with Dr. Perales because she was still having back pain and stiffness, along with leg pain. Dr. Perales reviewed the MRI results with employee CATALANELLO and on examination found that she had a positive straight leg raising test and a positive deep tendon reflex test as well as restrictions in range of motion of the lumbar spine. Dr. Perales' diagnosis then became a lumbar syndrome with an annular tear at L4-5, degenerative joint disease and right sciatica. He prescribed employee CATALANELLO a Medro Dose Pack, Darvocet, Celebrex and also restricted her from work.

On August 8, 2004, employee CATALANELLO presented to the emergency room at Illinois Valley Community Hospital because she was having swelling under her tongue after taking the prescription Celebrex for several days. She was instructed to discontinue taking the Celebrex since she had a reaction to it and to follow-up with Dr. Perales.

On August 9, 2004, Dr. Perales returned employee CATALANELLO to work with a 5 pound weight limit and no climbing, bending or stooping.

On August 17, 2004, employee CATALANELLO began receiving physical therapy for her complaint of low back pain, cramping and numbness in the toes, which were the same complaints she had immediately after her work injury. Employee CATALANELLO received approximately six weeks of therapy at Illinois Valley Community Hospital that ended on September 15, 2004.

On August 31, 2004, employee CATALANELLO saw Dr. Perales for a follow-up from the emergency room visit for her allergic reaction to Celebrex.

On October 27, 2004, Dr. Perales referred employee CATALANELLO back to physical therapy and employee CATALANELLO gave the therapist the following history:

"The patient states that she hurt her back March 2004 when she was attacked at work. She states that she started having pain in her lower back area, which she describes as cramping which goes down to the buttock area. She states that she was taken to the emergency room and x-ray was found to be negative for any fractures or dislocation. The patient states she has had physical therapy, which helped in relieving some of the pain in her lower back area. She states that she was released back to work in March and worked for about two months on a light duty, but she started having some problems in her back again so she consulted with Dr. Perales and she was ordered to have MRI and x-ray. She states that last on July 8, 2004, she had another MRI and she was told to take off work and started physical therapy again which she had done from July to September and made some improvements again. She states that ever since she stopped therapy in September she started having some cramping in her lower back area again so she went back to see the doctor and she was ordered to have physical therapy again. She is now referred physical therapy for continuation of treatment."

Employee CATALANELLO received physical therapy until November 18, 2004.

DR. GREGG DAVIS - INDEPENDENT MEDICAL EVALUATION

On December 8, 2004, employee CATALANELLO chose to be evaluated by Dr. Gregg Davis, a physician board certified in family practice. Employee CATALANELLO informed Dr. Davis that she was still experiencing low back complaints that were identical to those she had experienced at the time of her work injury. Employee CATALANELLO denied having any prior or subsequent injuries. Dr. Davis testified at his evidence deposition that employee CATALANELLO had degenerative disk disease of her lumbar spine, a herniated nucleus pulposus at L4-5 with an associated annular tear and right lower extremity radiculopathy. Dr. Davis believed that these conditions were related to employee CATALANELLO's work injury and he further believed she would need future medical care for control of her pain and would benefit also from permanent work restrictions.

DR. CONSTANTINO PERALES

On June 7, 2005, employee CATALANELLO returned to see Dr. Perales and complained of low back pain, more on the right side, cramping to thighs and having numbness to feet and toes. Dr. Perales testified at his evidence deposition that employee CATALANELLO was experiencing symptoms of a herniated disc or significant nerve impingement. Dr. Perales then referred her to a neurological specialist and his records indicate that he referred employee CATALANELLO to Dr. William Olivero.

DR. WILLIAM OLIVERO - ASSOCIATED UNIVERSITY NEUROSURGEONS

On August 3, 2005, employee CATALANELLO saw Dr. William Olivero and gave a history of being hurt at work over a year ago and since that time was having low back pain, cramping at the legs and numbness in the feet. Dr. Olivero performed an examination on her back which revealed decreased range of motion. He then ordered a repeat lumbar MRI, which he later interpreted as being unchanged from the previous MRI. Dr. Olivero recommended further physical therapy and epidural steroid injections.

On September 21, 2005, employee CATALANELLO returned to see Dr. Olivero after having had two epidural steroid injections in her low back. She reported experiencing some relief, so Dr. Olivero ordered her to have further injections. Dr. Olivero also prescribed physical therapy for another 4 weeks.

On November 9, 2005, employee CATALANELLO saw Dr. Olivero and reported that she was slightly better after the most recent epidural steroid injection. Dr. Olivero advised her that the next option would be either a fusion surgery or artificial disc replacement, so he referred employee CATALANELLO to his partner, Dr. Dzung Dinh, for evaluating the possibility of surgery.

DR. DZUNG DINH - ASSOCIATED UNIVERSITY NEUROSURGEONS

On November 28, 2005, employee CATALANELLO saw Dr. Dinh, who after reviewing the MRI's and examining employee CATALANELLO, was not sure if her pain was coming from the right sacroiliac joint or discogenic or a combination. Dr. Dinh believed that if her pain persisted after treatment to the sacroiliac region, then a discogram would be needed before any surgery. Dr. Dinh referred employee CATALANELLO to Dr. Lisa Snyder for further treatment for the low back and sacroiliac joint.

DR. LISA SNYDER - INSTITUTE OF PHYSICAL MEDICINE & REHABILITATION

On December 22, 2005, employee CATALANELLO saw Dr. Lisa Snyder with the chief complaint of low back pain. On examination, Dr. Snyder found mildly limited range of motion in her lumbar and tenderness along her lumbo-sacral para vertebrals. Dr. Snyder recommended that employee CATALANELLO have a different approach to physical therapy and continued to monitor her progress. On June 1, 2006 she saw Dr. Snyder and informed her that she managed her chronic low back pain by using a TENS unit eight to ten hours a day and by taking prescription medicine. Dr. Snyder referred employee CATALANELLO back to Dr. Dinh for further care.

DR. DZUNG DINH - ASSOCIATED UNIVERSITY NEUROSURGEONS

On March 7, 2007, employee CATALANELLO returned to see Dr. Dinh and complained of having sharp shooting pain into the left buttock. Dr. Dinh reviewed the most recent MRI done on January 16, 2007, which showed a dark disc at L4-5 and an annular tear. Dr. Dinh ordered water therapy and also ordered a discogram at L4-5 level.

On August 2, 2007, employee CATALANELLO underwent a lumbar discogram at St. Francis Medical Center, which demonstrated a grade IV tear pattern at the L4-5 level.

DR. GEORGE DEPHILLIPS

On February 13, 2009, employee CATALANELLO was referred by Dr. Perales to Dr. George DePhillips for another neurosurgical consultation and she gave Dr. DePhillips a history of being attacked by a resident and suffering low back pain immediately and over the past several years suffering with pain radiating into right buttock and thigh as well as calf to ankle with numbness and tingling in right foot. Dr. DePhillips reviewed the lumbar MRI which revealed dehydration and degeneration at L4-5 with a tear in the annulus. Dr. DePhillips explained to her that her low back pain is most likely due to the tear of the annulus. Dr. DePhillips requested records of the lumbar discogram before discussing any surgical options with employee CATALANELLO.

On June 22, 2009, when employee CATALANELLO saw Dr. DePhillips to review the discogram results, he had some concern over the validity of the discogram and recommended a follow-up discogram be done and another MRI scan.

On April 12, 2010, employee CATALANELLO returned to see Dr. DePhillips following her follow-up discogram done on March 11, 2010, by Dr. Patel. The discogram provoked concordant pain at L4-5 with contrast leakage consistent with disc protrusion. Dr. DePhillips explained to employee CATALANELLO that a fusion surgery was a reasonable option for her to consider. Dr. DePhillips stated in his records that the work injury most likely aggravated her pre-existing degenerative disc disease which the source of her low back pain.

DR. GEORGE DEPHILLIPS - EVIDENCE DEPOSITION (08/18/10)

On August 18, 2010, Dr. George DePhillips testified at his evidence deposition that at the time he first saw employee CATALANELLO in February 2009, he was provided with the treating physician's records and various radiology studies. The initial history employee CATALANELLO gave him was that on March 4, 2004, she was attacked in the bathroom and developed low back pain with pain radiating into the right buttock and posterolateral thigh and calf to the ankle with numbness and tingling in the right foot. She further indicated that conservative care only gave her temporary relief. She did not provide any history of trauma either before or after the work injury.

Dr. DePhillips review the lumbar MRI scan from 2007, which he interpreted as showing at the L4-5 level, dehydration and disk degeneration with a tear in the annulus. Dr. DePhillips testified that the significance of an annular tear is that it can cause inflammation which irritate the nerve endings and that the symptoms employee CATALANELLO complained of were consistent with the tear of the annulus at L4-5.

Dr. DePhillips further testified that his primary diagnosis was discogenic low back pain with L5 lower extremity radiculitis with a secondary diagnosis of sacroiliac dysfunction. Dr. DePhillips testified that trauma can cause tears of the annulus. Dr. DePhillips discussed with employee CATALANELLO, the possible courses of treatment consisting of living with the pain and continuing pain management through medication or surgery.

On June 22, 2009, employee CATALANELLO had a follow-up appointment with Dr. DePhillips and they reviewed the discogram performed in 2007. The discogram was reported as showing concordant pain at both the L4-5 level and L5-S1 level. Dr. DePhillips recommended a follow-up discogram since he question the test validity.

On April 12, 2010, employee CATALANELLO returned after undergoing the follow-up discogram and MRI. The recent discogram provoked a concordant pain at L4-5 level and the dye in the annulus indicated an annular tear. The MRI scan revealed disc degeneration at L4-5 level with disc bulging. Dr. DePhillips recommended a one-level fusion surgery if employee CATALANELLO wished to proceed with surgery. Dr. DePhillips believed employee CATALANELLO was unemployable and disabled. Dr. DePhillips was of the opinion that the surgery was causally related to the work injury on March 4, 2004.

On cross-examination, Dr. DePhillips stated that was unaware of any trauma that employee CATALANELLO suffered before or after the work injury. Dr. DePhillips was questioned whether he aware that on June 21, 2006, employee CATALANELLO fell over a railing and sustained a chest wall contusion and also whether he was aware that on March 20, 2007, employee CATALANELLO was a victim of domestic abuse. Dr. DePhillips testified that his opinions would not change in light of these incidents because employee CATALANELLO was already symptomatic in terms of back pain, bilateral leg pain and discogenic pain before these subsequent events. Dr. DePhillips stated that the subsequent traumatic events may have aggravated her condition, but the initial onset of her condition was causally related to the work injury.

On cross-examination, Dr. DePhillips further stated that he was unaware that employee CATALANELLO was released to return to work from Occupational Health Department two weeks after her injury. Dr. DePhillips testified that it is not uncommon for patients who have been injured to experience improvement in the muscle sprain, strain ligamentous strain and then within eight weeks, show symptoms of discogenic pain.

Dr. DePhillips testified that the symptoms a patient would have indicating an annular tear would be worsening low back pain, radiculitis, spasms in paraspinal muscles, numbness and tingling. Initially, the patient starts to experience low back pain which progressively worsens.

On redirect examination, Dr. DePhillips reviewed the lumbar MRI reports for July 8, 2004 and August 2005, and they showed an annular tear. These MRI's were done long before any subsequent trauma. The lumbar MRI's for 2007 and 2010 also show the same annular tear, indicating that any subsequent trauma did not aggravate the annular tear. Dr. DePhillips concluded his testimony by stating that there was no indication that any of these subsequent events to employee Catalanello affected her low back condition.

DR. CONSTANTINO PERALES - EVIDENCE DEPOSITION (02/11/11)

On February 11, 2011, Dr. Constantino Perales testified that his medical practice consists of treating a significant number of patients who have been injured at work or in motor vehicle accidents.

On July 1, 2004, Dr. Perales first saw employee CATALANELLO, who gave a history of sustaining a back injury in March 2004 and complained of back pain and cramping in her buttocks and right flank area. On examination, Dr. Perales found mild tenderness of the lumbar spine and positive straight leg raising. His diagnosis was back pain, lumbar syndrome and he ordered a lumbar MRI.

On July 8, 2004, the MRI report indicated that employee CATALANELLO had a small broad-based L4-5 disc protrusion with annular tear. Dr. Perales further testified that in his opinion, there was a correlation between employee CATALANELLO's physical complaints and the findings made by the radiologist of a protruding disc with an annular tear. Dr. Perales diagnosed employee CATALANELLO with having a lumbar syndrome with annular tear, degenerative arthritis or degenerative joint disease and right sciatica. He then ordered physical therapy, a steroid pack and Celebrex.

On August 31, 2004, employee CATALANELLO had a follow-up appointment with Dr. Perales concerning her allergic reaction to Celebrex. Dr. Perales agreed that the emergency room treatment employee CATALANELLO received was related to an allergic reaction she had to the Celebrex.

On October 7, 2004, employee CATALANELLO reported to Dr. Perales that her low back pain was slightly improved, but that she was still getting cramps in her lumbar spine. Dr. Perales found on examination, that she had slight tender spasm of the lumbar spine and some positive findings of nerve impingement. Dr. Perales sent her back for further physical therapy and refilled her prescription medicine.

On December 15, 2004, Dr. Perales provided a narrative report indicating that employee CATALANELLO gave a history of being assaulted by a resident who pushed and kicked her in the lower back area. Based upon his examination and MRI findings, Dr. Perales diagnosed her with lumbar syndrome with a disc protrusion and annular tear at L4-5 and right sciatica. Dr. Perales further stated in his report, that employee CATALANELLO's current back problem was causally related to her work injury and that she may need to be evaluated by a neurosurgeon.

Dr. Perales testified that he continued to treat employee CATALANELLO over the next six years and his opinions regarding accident and causal connection to the injury have not changed. Dr. Perales further indicated that employee CATALANELLO's condition has progressed to the point where surgery is an open option for her.

On June 7, 2005, employee CATALANELLO reported to Dr. Perales that there was an exacerbation in her lower back pain, as well as cramping and numbness to both feet and toes. A physical examination revealed tenderness of the lumbar spine and the straight leg test worsened the symptoms. Dr. Perales recommended referral to a neurosurgeon because she had clear symptoms of a herniated disc or significant nerve impingement.

On December 1, 2005, Dr. Perales examined employee CATALANELLO, who had no significant improvement in her low back. He refilled her prescription of Vicodin and continued her on physical therapy.

On June 20, 2006, employee CATALANELLO saw Dr. Perales and complained of persistent low back pain and difficulty walking. Dr. Perales continued on with his same management.

On June 28, 2006, employee CATALANELLO presented to Dr. Perales with an unrelated condition where she suffered a contusion to her left ribs. She made no complaints that her low back condition worsened as a result of this incident. On subsequent visits for treatment of her left rib condition, she did not make any complaints that the trauma to the ribs worsened her low back pain.

On January 9, 2007, employee CATALANELLO saw Dr. Perales and complained that her low back pain was worse over the past month and that she also noticed some lumps on the lower right of her back side that were causing her pain. Dr. Perales ordered a MRI of the lumbar area, which showed a broad-based disc bulge and annular tear at the L4-5 level. Dr. Perales believed that the MRI findings were similar to the MRI findings in 2004, with the possible evidence of some healing. On April 12, 2007, employee CATALANELLO saw Dr. Perales for injuries she sustained to her head as a result of domestic violence. Employee CATALANELLO did not make any complaints that her low back condition had changed at all following the domestic violence.

On January 8, 2008, employee CATALANELLO saw Dr. Perales and indicated that her low back pain was essentially unchanged. Dr. Perales referred her to Dr. DePhillips, a neurosurgeon, for a second opinion. On June 12, 2008, employee CATALANELLO complained to Dr. Perales that her low back pain seemed to be a little worse and examination of the lumbo-sacral spine revealed some impingement of the nerves.

On June 26, 2008, employee CATALANELLO stated to Dr. Perales that she was still having low back pain everyday and that the pain was constant.

On November 18, 2008, employee CATALANELLO told Dr. Perales that she had morning stiffness and cramping in her legs. His diagnosis was chronic low back pain and parasthesias of the lower extremities. On January 20, 2009, employee CATALANELLO had a follow-up visit with Dr. Perales and stated that her low back pain was unchanged and that it was radiating down her right leg. Dr. Perales received a copy of Dr. DePhillips' consultation report on employee CATALANELLO and his assessment of her low back condition was essentially the same as Dr. Perales' assessment.For the remainder of 2009, Dr. Perales recommended that employee CATALANELLO follow-up with Dr. DePhillips.

On January 27, 2010, employee CATALANELLO complained to Dr. Perales that she had increase in back pain and severe right buttock pain for the past two weeks. Dr. Perales' physical exam indicated that she had more nerve impingement in the lumbar spine. On April 2, 2010, employee CATALANELLO had a lumbar MRI with findings that were consistent with the previous lumbar MRI's. On July 13, 2010, employee CATALANELLO discussed with Dr. Perales that she did not want surgery at the present time. Dr. Perales recommended home exercises as well as using the YMCA for guidance. For the remainder of 2010, Dr. Perales maintained employee CATALANELLO on her prescription medications and home exercises. His diagnosis was chronic pain syndrome, chronic lumbar syndrome, parasthesias of the legs, weakness of the legs and right sciatica.

On February 9, 2011, Dr. Perales saw employee CATALANELLO for her low back pain and he continued her on the same treatment regimen. Dr. Perales testified at his deposition that employee CATALANELLO continued to be disabled and he didn't see her returning to any kind of gainful activity since her ongoing back problem appeared to be progressing. Dr. Perales further stated that his treatment to her low back condition and the pain medication he prescribed was causally related to her back injury. Dr. Perales also testified that employee CATALANELLO's conditions of ill-being could be permanent in nature.

On cross-examination, Dr. Perales testified that he is not board certified in any specialty and his practice is a combination of internal medicine and occupational medicine. Dr. Perales testified that he referred employee CATALANELLO to neurosurgeons for consultation. He further testified that as a primary care physician, he monitors the patient and takes care of the prescription needs of the patient.

Dr. Perales testified that from 2004 through the time of his deposition, he has treated employee CATALANELLO's low back injury and has prescribed pain medications. Initially he prescribed Darvocet, which was later taken off the market. He then switched her to Vicodin, which is a synthetic codeine. He then tried her on a prescription for Percocet, which is a slightly different type of codeine. On July 17, 2006, he switched her over to Roxicodone, which is also known as oxycodone. Dr. Perales testified that unless the patient has pain issues, he would not normally keep a patient on oxycodone for three or four years. Dr. Perales did not believe that employee CATALANELLO had any type of problem with addictive medication.

Dr. Perales was questioned regarding employee CATALANELLO's incident where she slipped and fell carrying groceries and her right ribs hit the railing and he testified that he did not notice any increase in her low back symptoms. Dr. Perales stated that he did not have any evidence that the injury to the rib exacerbated any of her back symptoms. Dr. Perales also testified that the domestic violence incident did not change her low back symptoms.

DR. STEVEN DELHEIMER – SECTION 12 REPORT (08/24/04)

On August 24, 2004, at her employer's request, employee CATALANELLO was evaluated by Dr. Steven Delheimer at which time and she stated the following physical complaints:

> "At this time she complains of pain involving her back, which radiated into both legs (right > left). The pain is aggravated by prolonged standing. The leg pain, when present, is much worse than the back pain. She describes the pain as a
> charley horse - burning type sensation associated with muscle spasm. The pain, however, is now infrequent and occurs about once a month. She indicates that the pain is definitely to a lesser degree than at the time of the initial injury."

In his report, Dr. Delheimer lists various records he reviewed, but he failed to mention the March 17, 2004, physical therapy note from Illinois Valley Community Hospital, which indicated:

> "Pain Rating (0-10): Start 05/10 End 3/10 Location:
> ROM: (+) TTP of L pubic (+) spring test on R more than L."

Dr. Delheimer stated in his report that :

> "I would like to emphasize, however, that Ms. Catalanello's pain has significantly improved since then and her radicular symptoms have resolve."

Dr. Delheimer stated in his recommendation section of his report that:

> "In the absence of any radicular pain, I believe Ms. Catalanello is capable of returning to work light duty with no lifting greater than 20 pounds and no excessive flexion / extension. These restrictions should remain in effect for a period of two weeks after which I anticipate Ms. Catalanello will be capable of returning to work without restriction.

> I do not believe she needs any further diagnostic studies or treatment relative to the March 4, 2004 incident, and consider her to be at or approaching maximal medical treatment effective today, August 24, 2004."

On September 9, 2004, Dr. Delheimer received a phone call from Ms. Tara Burkett of Cambridge Integrated Services Group, and he immediately changed his opinions concerning MMI. Dr. Delheimer claimed that he was originally "unaware" that Ms. CATALANELLO did not have medical treatment from March 18, 2004 to July 1, 2004, even though Dr. Delheimer had the medical records.

Dr. Delheimer changed his opinion and claimed that Ms. CATALANELLO reached MMI toward the end of March 2004 and that none of Dr. Perales' treatment was causally related to the work incident of March 4, 2004.

DR. STEVEN DELHEIMER – SECTION 12 REPORT (01/23/07)

On January 23, 2007, employee CATALANELLO was re-evaluated by Dr. Steven Delheimer and she stated the following physical complaints:

> "At this time, Ms. Catalanello complains of pain involving her low back. The pain is worse on the right side than on the left. She is uncomfortable if she sits or stands for too long. She complains of some cramping of the inner thighs but is nonradicular."

Since the time that Dr. Delheimer initially evaluated employee CATALANELLO on August 24, 2004, she received treatment for her back condition from Dr. William Olivero, Dr. Dzung Dinh, Dr. Lisa Snyder and Dr. Ronald Kloc. Employee CATALANELLO underwent two lumbar MRI's epidural steroid injections, facet blocks, trigger point injections, physical therapy and discogram. Dr. Delheimer performed a physical examination on employee CATALANELLO and found the examination to be normal. Dr. Delheimer expressed the opinion that following employee CATALANELLO's work injury on March 4, 2004, she reached maximum medical improvement on March 18, 2004 and could work full duty. Dr. Delheimer did not believe any of the treatment employee CATALANELLO received from Dr. Olivero, Dr. Dinh, Dr. Snyder and Dr. Kloc, was related to her work injury.

DR. STEVEN DELHEIMER - DEPOSITION (05/19/09)

Dr. Delheimer testified that in the past, he has conducted medical examinations for Cambridge Integrated Services Group and that in general, 80% of his evaluations are for employers. Dr. Delheimer admitted that after he wrote his August 24, 2004 report, the insurance adjuster called him and pointed out that there was a gap in treatment from March 18, 2004 to July 1, 2004.

Dr. Delheimer changed his opinion from finding employee CATALANELLO at maximum medical improvement on August 24, 2004, to finding her at maximum medical improvement on March 18, 2004.

Dr. Delheimer reviewed the July 8, 2004 lumbar MRI and made no mention of the annular tear noted by the radiologist. He stated that he did not believe an annular tear was significant since nobody has ever proven that it causes pain. Later in his deposition, Dr. Delheimer admitted that there are other neurosurgeons who believe that there is a chemical change when there is an annular tear that the chemical can irritate the nerve roots.

Dr. Delheimer admitted that he was not provided with employee CATALANELLO's January 16, 2007 lumbar MRI at the time of his re-evaluation on January 23, 2007 or at the time of his deposition on May 19, 2009.Dr. Delheimer stated that he was never provided with medical records to suggest that employee CATALANELLO ever had back pain in the past and did not have any subsequent injury to her low back.

Dr. Delheimer, effectively Respondent's expert witness throughout the case was not provided with any of Dr. Perales' medical records after July 1, 2004.

Dr. Delheimer stated that from a clinical standpoint, employee CATALANELLO's March 10, 2004 complaints were consistent with the complaints she made to him on August 24, 2004 and consistent with the January 23, 2007 examination. Dr. Delheimer admitted that he did not find any symptom magnification. (emphasis added)

Dr. Delheimer was also unaware that Dr. Dinh had a discogram performed on August 7, 2007 that showed concordant pain at L4-5. Even though Dr. Delheimer does not rely on a discogram, he admitted that there are other neurosurgeons who do use it to determine necessity for surgery.

DR. STEVEN DELHEIMER - IME REPORT (11/04/09)

On November 4, 2009, employee CATALANELLO was re-evaluated by Dr. Steven Delheimer and she stated to him the following physical complaints:

> "At the time of this evaluation, she complains of low back pain, which is lumbar in location. In addition, she complains of some buttock pain that will vary from side to side and is described as a burning sensation. She also experiences charley horses involving her calves, which is bilateral; neither side is worse than the other."

Dr. Delheimer reviewed the lumbar MRI dated January 16, 2007 and concluded that it only showed degenerative disc disease at L4-5 level. Dr. Delheimer stated that employee CATALANELLO suffered a soft tissue injury and had long since reached maximum medical improvement.

DR. STEVEN DELHEIMER - DEPOSITION (06/22/11)

On June 22, 2011, Dr. Steven Delheimer testified that he re-evaluated employee CATALANELLO on November 4, 2009. He reviewed the lumbar MRI dated January 16, 2007 and did not notice any significant changes in the L4-5 level from the prior studies.

Dr. Delheimer was of the opinion that employee CATALANELLO was not a surgical candidate and did not need a discogram.Dr. Delheimer testified that when he examined employee CATALANELLO on November 4, 2009, he did not note any Waddell signs indicating symptom magnification.

Dr. Delheimer admitted that there could be some minor bulging of the L4-5 disc. He further testified that he did not appreciate any tears of the disc, although the radiologist did make the finding. Dr.. Delheimer agreed that other reasonable neurosurgeons do use the results from discograms to treat their patients with disc problems. He also acknowledged that both Dr. Dinh and Dr. DePhillips ordered discograms.

Dr. Delheimer further stated that there are nerves that innervate the annulus and that would be where the pain is generated. Dr. Delheimer testified that he reviewed the MRI of the lumbar spine of July 8, 2004 and did not see an annular tear. Dr. Delheimer testified than an annular tear can heal in months. However, the MRI's and discograms consistently demonstrate an annular tear at L4-5 level.

F. IS THE PETITIONER'S PRESENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY?

Employee CATALANELLO testified that she was in her usual state of good health and never had any injury to her low back before working for employer, Horizon House of IV, Inc. All the medical records and deposition testimony entered into evidence as well as the medical reports from all the physicians, substantiate that employee CATALANELLO never had any prior medical treatment for her back.

Employee CATALANELLO also testified that on March 4, 2004, she was assaulted by a resident who came up from behind her and punched and kicked her in the low back. She immediately experienced pain in her low back and right hip and sought medical care at the emergency room of Illinois Valley Community Hospital. The emergency room physician initially diagnosed her with trauma to the right lower back and iliac crest and on March 10, 2004, the Occupational Health Department physician diagnosed her with low back pain, muscles spasms, hematoma and radiating pain.

On July 1, 2004, employee CATALANELLO came under the care of Dr. Constantino Perales, who diagnosed her with low back pain and ordered a lumbar MRI, which showed a broad-based L4-5 disc protrusion with annular tear. Follow-up lumbar MRI's and discograms consistently showed an annular tear at L4-5 level.

On December 8, 2004, Dr. Gregg Davis performed a medical evaluation on employee CATALANELLO and diagnosed her as having a herniated disc at L4-5 with an associated annular tear and right lower extremity radiculopathy. Dr. Davis testified at his evidence deposition that there was a causal connection between employee CATALANELLO's medical conditions and her work injury on March 4, 2004.

On December 15, 2004, Dr. Constantino Perales indicated in his report, that employee CATALANELLO had contusions to her lumbar spine, had a lumbar syndrome with annular tear of L4-5, disc protrusions at L4-5 level and sciatica. Dr. Perales found that these conditions were causally related to her injury at work.

On February 11, 2011, Dr. C. Perales testified at his evidence deposition that he continually treated employee CATALANELLO for her low back conditions from July 1, 2004, up until the time of his deposition, and it was his medical opinion that her low back condition is related to her injury at work.

On August 18, 2010, Dr. DePhillips testified at his evidence deposition that employee CATALANELLO's low back condition was causally related to her work injury.

Employer, HORIZON HOUSE OF IV, INC., requested that Dr. Steven Delheimer examined employee CATALANELLO on three separate occasions and opined that she sustained a soft tissue injury to her low back and reached maximum medical improvement on March 18, 2004.

The Arbitrator adopts the opinions of employee CATALANELLO's treating physicians, Dr. Perales and Dr. DePhillips, which are supported by the Peoria doctors. The Arbitrator finds as a matter of law and fact Petitioner's current condition of ill-being is causally related to the work injury she sustained on March 4, 2004 in the case at bar. No facts or co-morbidities break the chain of causation.

J. WERE 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 following exhibits regarding employee CATALANELLO's medical expenses and reimbursement claims, were admitted into evidence:

(PX. 14)	Hospital Radiology Service	$ 343.43
(PX. 15)	Illinois Valley Community Hospital	$ 4,745.72
(PX. 16)	Dr. Ruben Santos	$ 16.60
(PX. 17)	Central Illinois Radiological	$ 2,379.00
(PX. 18)	Peru Anesthesia	$ 484.62
(PX. 19)	Institute of Physical & Rehabilitation	$ 1,127.00
(PX. 20)	EMPI	$ 2, 128.60
(PX. 21)	St. Margaret's Hospital	$ 3,073.61

(PX. 22)	Joliet Radiological Service Corp.	$ 198.00
(PX. 23)	RS Medical $ 690.64	
(PX. 24)	Central Illinois Pathology $ 300.00	
(PX. 25)	Heating pad $ 17.99	
(PX. 26)	Associated University Neurosurgeons	$ 90.00
(PX. 27)	Dr. George DePhillips$ 450.00	
(PX. 28)	Ameritox $ 686.78	
(PX. 29)	Dr. Constantino Perales $ 4,663.00	
(PX. 30)	Prescriptions (Osco / CVS/ Walgreens/ K-Mart)	$ 4,368.25
(PX. 31)	Prescriptions (Family Pharmacy)	$ 70.928.74
	TOTAL $ 96,691.98	

At hearing, employer, HORIZON HOUSE OF IV, INC., objected only to liability for petitioner's exhibits #14 - #31; Since it has been found as a matter of law the Petitioner sustained an accidental injury on March 4, 2004 and that her current condition is causally related to this accident, the Arbitrator further finds respondent liable for the medical expenses shown in petitioner's exhibits #14 though #31. The Arbitrator, therefore, orders respondent to pay to the Petitioner and her attorney Mr. Olivero the outstanding medical bills in accordance with Section 8(a) of the Act, subject to Section 8.2 Medical Fee Schedule& regulations.. Respondent is entitled to credit for all medical expenses actually paid before date of close of proofs on July 23, 2013.

K. WHAT TEMPORARY BENEFITS ARE IN DISPUTE? ?

On March 4, 2004, while employee CATALANELLO was leaning over a bathtub assisting a resident, she was physically assaulted by another resident who came up from behind and began punching and kicking employee CATALANELLO in the low back. Following the attack, employee CATALANELLO had to seek immediate medical attention because she could not straighten up her back and she was experiencing numbness in her right buttock area.

Employee CATALANELLO was treated in the emergency room at Illinois Valley Community Hospital on March 4, 2004, and followed up with the Occupational Health Department where she received physical therapy treatment. On March 18, 2004, employee CATALANELLO was released to return to work. Employer, HORIZON HOUSE OF IV, INC., paid TTD benefits from March 5, 2004 through March 18, 2004.

Employee CATALANELLO testified that she returned to work, but was unable to perform her full duties so her employer assigned her to a light-duty position as a van driver. She further testified that her back injury continued to cause her problems so she sought further medical attention from Dr. Constantino Perales.

On July 1, 2004, Dr. Perales examined employee CATALANELLO and ordered a lumbar MRI. ON July 22, 2004, Dr. Perales reviewed the lumbar MRI findings with employee CATALANELLO, which showed a broad-based L4-5 disc protrusion with annular tear. Dr. Perales took employee CATALANELLO off-work from July 22, 2004 to August 6, 2004. The medical records from employee CATALANELLO's treating physicians after August 6, 2004, did not address employee CATALANELLO's temporary disability status.

The Arbitrator finds that employee CATALANELLO is entitled to receive TTD payments in the amount of $229.52 per week from March 5, 2004 through March 10, 2004 and July 22, 2004 through August 6, 2004, representing 5 weeks.

L. WHAT IS THE NATURE AND EXTENT OF THE INJURY?

On March 4, 2004, employee CATALANELLO was assaulted by a resident and injured her back. She received conservative medical treatment consisting of physical therapy, back brace, TENS unit, prescription medication and epidural steroid injections. She received only temporary relief from her low back pain, but only a temporary basis.

The first lumbar MRI on July 8, 2004, showed a broad-based L4-5 disc protrusion with an annular tear. A repeat lumbar MRI on August 12, 2005, showed no change in the condition of L4-5 disc. On January 16, 2007, another lumbar MRI showed a dark disc and an annular tear. On August 2, 2007, a post-discogram CT demonstrated a grade IV tear pattern at L4-5 level. On March 11, 2010, a repeat discogram provoked pain at L4-5 with contrast leakage consistent with a disc protrusion.

Employee CATALANELLO testified that she has not made a determination whether to proceed with back surgery, "but would like to have surgery as an option in the future." She testified that she takes medication to control her back pain. Without the medication, her back feels very stiff, hurts and is uncomfortable. Employee CATALANELLO testified that her daily routine consists of her getting up and just trying to do as much as she can. She cleans a little bit, then has to sit down and rest. She does not believe that she could return to work as a training assistant for disabled adults.

Employee CATALANELLO testified that she still experiences low back pain that severely limits her every day activities. Dr. George DePhillips testified that on April 12, 2010, employee CATALANELLO became totally disabled. Dr. Perales testified at his deposition on February 11, 2011, that employee CATALANELLO was totally disabled.

The Arbitrator finds based upon the totality of the medical evidence that the Petitioner in the case at bar is medically totally and permanently disabled under the Act.. Respondent shall pay to petitioner and her attorney the sum of $382.40 per week for life, commencing April 12, 2010, as provided in Section 8(f) of the Act.

O. OTHER - CHOICE OF PHYSICIANS

On March 4, 2004, employee CATALANELLO was injured at work and had to be treated immediately for her injuries at the emergency room of Illinois Valley Community Hospital. The discharge instructions from the emergency room physician were:

": Follow-up with Occupational Health on 3-5-04 — 1 pm"

On March 5, 2004, employee CATALANELLO complied and followed up with the Occupational Health Department of Illinois Valley Community Hospital, where she received physical therapy and was taken off-work until March 8, 2004. On March 10, 2004, employee CATALANELLO returned to Occupational Health Department because she was unable to work due to the pain in her low back, right leg, thigh and pelvis.

On March 18, 2004, Occupational Health Department released employee CATALANELLO to return to work. Employee CATALANELLO testified that she returned to work, but could not perform her full duties due to her low back pain and stiffness. Employer, HORIZON HOUSE OF IV, INC., accommodated by assigning her to a light-duty job as a driver of a transportation van. On July 1, 2004, employee CATALANELLO had to seek further medical care from Dr. Constantino Perales because she continued to have low back pain. On June 7, 2005, employee CATALANELLO saw Dr. Perales again and complained of lower back pain along with numbness to both toes and feet. Dr. Perales' chart note indicates that he referred employee CATALANELLO for a neurosurgical consult.

Dr. Perales testified at his evidence deposition that on June 30, 2005, he had a referral sheet for employee CATALANELLO to see Dr. Olivero, a neurosurgeon at OSF St. Francis, Peoria, Illinois. On August 3, 2005, employee CATALANELLO began treating with Dr. Olivero for her low back conditions and he ordered a repeat lumbar MRI, re-started physical therapy for employee CATALANELLO and ordered epidural steroid injections at the local hospital.

Employee CATALANELLO then saw Dr. Ronald Kloc, a pain management specialist at Illinois Valley Community Hospital for three epidural steroid injections ordered by Dr. Olivero. Dr.Olivero also referred employee CATALANELLO to his partner, Dr. Dzung Dinh, for possible back surgery.

On November 9, 2005, employee CATALANELLO saw Dr. Dzung Dinh, who referred her to Dr. Lisa Snyder for conservative treatment for her low back pain and sacral iliac dysfunction treatment. Dr. Dinh also considered the possibility of ordering a discogram prior to back surgery.On December 22, 2005, employee CATALANELLO saw Dr. Snyder for her low back pain and Dr. Snyder re-started physical therapy, prescribed a TENS unit and gave her trigger point injections. On June 1, 2006, Dr. Snyder referred employee CATALANELLO back to her primary care physician, Dr. Perales, for further follow-up care.

On August 2, 2007, Dr. Lawrence Wang performed a discogram on employee CATALANELLO that had been ordered by Dr. Dzung Dinh.

On January 27, 2010, employee CATALANELLO saw Dr. Perales complaining of pain in her low back with severe right buttock pain. Dr. Perales then referred her to Dr. George DePhillips, neurosurgeon, for possible nerve impingement in the lumbar spine.

On February 13, 2009, employee CATALANELLO saw Dr. George DePhillips and he requested to be provided with the lumbar discogram to review. On June 22, 2009, Dr. DePhillips reviewed the lumbar discogram and determined that he needed a repeat discogram in order to validate the results.

On March 11, 2010, employee CATALANELLO underwent a repeat discogram by Dr. Patel as ordered by Dr. DePhillips.

The Arbitrator finds as a matter of law that all of employee CATALANELLO's medical providers were either within her two choice of medical providers or within the covered chain of referrals.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

PATRICIA MADISON,

Petitioner,

vs.

NO: 09 WC 11776

15IWCC0059

WalMart Associates,

Respondent.

DECISION AND OPINION ON REVIEW

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

The Commission finds that the medical expenses awarded by the Arbitrator should have been payable by Respondent to the Petitioner directly, not to the actual medical providers. While it is common for employers to pay providers directly prior to a hearing on an undisputed case, Section 8(a) of the Act dictates that medical compensation "shall be paid to the employee". As such, the Arbitrator's award should have stated that any remaining outstanding medical expenses should be paid by Respondent to Petitioner, not the medical providers.

The amount the Petitioner is entitled to as awarded medical expenses is limited to a) only those medical expenses which are related to her right hip condition, b) only those medical expenses which remain outstanding and unpaid, and c) the fee schedule amounts related to such causally related unpaid medical expenses.

As correctly noted by the Arbitrator, several of the bills submitted into evidence are for services involving preexisting conditions such as cardiac care, and unrelated to Petitioner's right

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hip condition. Petitioner is not entitled to payment of such unrelated expenses from Respondent. Additionally, as noted by the Arbitrator, the vast majority of the submitted medical bills are noted to have been paid, with outstanding balances totaling a figure much smaller than what Petitioner is seeking per her brief. The Arbitrator also noted that it was impossible to tell, based on the evidence submitted, whether some of the bills had an outstanding balance or not.

The Commission wishes to commend the Arbitrator for the obviously significant amount of time spent reviewing the medical bills Petitioner put into evidence, as well as the records of workers compensation and group health payments made by Respondent's carriers. However, this is not something that the parties should have left to the Arbitrator to do. The parties should have taken the time prior to hearing to determine which bills were or were not causally related to the Petitioner's hip injury, what was owed on such bills pursuant to the fee schedule and whether they were paid or not. Not doing so is a big part of the confusion surrounding this issue.

Again, there are medical charges that were submitted into evidence by Petitioner which are unrelated to her hip injury, and neither party has submitted the fee schedule amounts due for the outstanding medical bills, so the Commission cannot provide a specific figure as a medical award. The parties shall first determine which bills are causally related to Petitioner's hip injury. The parties shall then determine the fee schedule amounts due for those bills. Once that is determined, the parties shall determine which bills remain outstanding, i.e. unpaid by the Respondent, its workers compensation carrier and/or its group health carrier. Once the outstanding expenses are determined, the Respondent shall pay the fee schedule amounts of any and all of these causally related outstanding bills directly to Petitioner, not the medical providers.

Because the amount of the unpaid medical expenses, at the fee schedule amounts, is currently unknown, the bond does not include any amounts for medical expenses, and does not deduct any credit to Respondent other than the $5,000.00 in permanency advanced by Respondent.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's decision is modified as indicated above.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $237.67 per week for a period of 129 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the loss of use of 60% of the right leg.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the outstanding medical expenses that have not been previously paid, as indicated above, pursuant to §§8(a) and 8.2 of the Act.

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

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

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Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $25,700.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JAN 2 3 2015
TJT: pvc
o 12/1/14
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

MADISON, PATRICIA
Employee/Petitioner

Case# **09WC011776**

WAL-MART & ASSOCIATES
Employer/Respondent

15IWCC0059

On 4/7/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.06% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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PEORIA, IL 61603

2593 GANAN & SHAPIRO PC
JESSICA BELL
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PEORIA, IL 61602

15IWCC0059

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
CORRECTED ARBITRATION DECISION

Case # 09 WC 11776

Consolidated cases: _____

Patricia Madison
Employee/Petitioner

v.

Wal-Mart Associates
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 **Douglas McCarthy**, Arbitrator of the Commission, in the city of **Peoria**, on **1/22/2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☐ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☐ 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 **12/26/2008**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$19,615.44**; the average weekly wage was **$377.22**.

On the date of accident, Petitioner was **53** years of age, ***married*** with **0** dependent children.

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

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

ORDER

Arbitrator finds that the Respondent is to pay for all the reasonable and necessary bills as explained in the attached conclusions of law, pursuant to the fee schedule.

Respondent shall pay Petitioner permanent partial disability benefits of **$237.67**/week for **129** weeks, reduced by **$5,000 for the credit on permanency advanced**, because the injury sustained caused the **60%** loss of use of Petitioner's right leg as provided in Section 8(e)(12) of the Act.

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

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

D. Daniel McCarthy
Signature of Arbitrator

March 24, 2014
Date

APR 7 - 2014

ARBITRATOR'S FINDINS OF FACT

The Petitioner filed an Application for Adjustment of claim on March 17, 2009, alleging an injury that petitioner sustained on December 26, 2008. The Petitioner in the Application alleged that on December 26th, she was injured at work, when she "fell in designated parking lot". See Petitioner's Exhibit 1.

The issues in dispute are nature and extent and whether there are any outstanding related medical bills for which the Respondent would be responsible.

At arbitration, Petitioner testified the she was 58 years of age, married with zero dependent children. Petitioner testified that she is currently not employed and is collecting Social Security Disability. Petitioner testified that she started working for Wal-Mart sometime in 2007 stocking groceries. Petitioner testified that on December 26th, 2008 she was working at East Peoria IL Wal-Mart, and was injured as a result of a fall in the designated parking lot.

Dr. Merkly an orthopedist with Midwest Orthopedics diagnosed the Petitioner with **"Right Hip Intertrochanteric Hip Fracture".** Petitioner's Exhibit 6. The following day, the doctor performed an open reduction with internal fixation of the fracture.. Petitioner's Exhibit 6.

Midwest Orthopedics medical records reveal that after the surgery of December 27, 2008, the Petitioner continued to follow up with Dr. Merkley and underwent physical therapy and work hardening. Petitioner's Exhibit 6. Dr. Merkley recommended a Functional Capacity Evaluation that Petitioner Underwent on December 17, 2009. Petitioner's Exhibit 6. The Functional Capacity Evaluation was entered and admitted into evidence as Petitioner's Exhibit 8. The FCE demonstrated valid and consistent effort on the part of the Petitioner. Petitioner's Exhibit 8. After the FCE, Dr. Merkley placed following permanent restriction on the Petitioner

> **"I would place permanent restriction on her of 10lb lifting restriction in all planes. Flat level work, no working at heights, no repetitive kneeling, bending, squatting, twisting or turning and a 30lb. push/pull limitation". Petitioner's Exhibit 6. Treatment date of 3-12-10.**

Dr. Merkley at that time also opined that **"Possible need for medical intervention in the future for her per trochanteric fracture which is healed would include possible hardware removal due to hardware sensitivity or corticosteroid injection".** Petitioner's Exhibit 6. Treatment date of 3-12-10.

The Arbitrator further notes that the Petitioner again followed up with Midwest Orthopedics and saw Dr. Merkley with continued complaints of right hip and leg pain. Petitioner's Exhibit 6. Dr. Merkley then referred the Patient to Dr. Mulvey, another specialist and Midwest Orthopedics. Petitioner's Exhibit 6. Dr. Mulvey on October 3, 2011 performed a right total hip implant with removal of the hardware from the prior surgery. In surgery, the doctor notes that an artificial femoral head and acetabulum were implanted. Petitioner's Exhibit 7.

At Respondent's request, Petitioner presented to Dr. Lawrence Lieber for an independent medical examination (IME) on December 21, 2011, after her total hip replacement. Dr. Lieber opined that the need for hip replacement was due to the initial injury of December 26, 2008. Dr. Lieber placed permanent restrictions on Petitioner of 25 pounds lifting on a regular basis, work at ground level only, minnimal bending and stooping. (RX 4)

Bill Taylor, an assistant manager of East Peoria Walmart testified on behalf of Respondent. Mr. Taylor also testified regarding a "Bona Fide Job Offer" that was made to Petitioner. Mr. Taylor testified he prepared the "Bona Fide Job Offer" marked as Respondent's Exhibit 1 and entered into evidence at trial. Ms. Taylor testified that the job offer was based on Petitioner's permanent restrictions that were placed on Petitioner per Dr. Merkley. Mr. Taylor testified that the job offer consists of different jobs that Petitioner would be doing different days. Mr. Taylor testified that once the job offer is made, the Petitioner had to contact him or the store in order to accept the offer. Mr. Taylor testified that once the offer is accepted than the job duties are explained. Mr. Taylor on cross admitted that the job offer is not explained prior to the acceptance of the offer.

Petitioner testified that she received the "Bona Fide Job Offer " but based on her understanding of the job offer it she thought that she would be unable to perform the job duties. .

Petitioner also testified that as a result of the injury, she still experiences pain in her right leg and hip. Petitioner testified that she is unable to put her weight down on her right leg. She testified that she uses over the counter pain killers and also follow up with Dr. Mulvey every few months. Petitioner testified that as a result of the injury, she is unable to run, garden and engage in activities she was able to prior to the injury. At the time of the Arbitration, Petitioner's husband Greg Madison also testified. Mr. Madison description of Ms. Madison was consistent with Ms. Madison's testimony. Mr. Madison testified that Ms. Madison has a hard time with sitting and standing for a prolonged period of time.

CONCLUSIONS OF LAW

Nature and Extent

When she was injured, the Petitioner worked for the Respondent stocking groceries, a job which she had held for approximately one year. Following her initial surgery and rehabilitation, she was placed on restrictions by her surgeon. However, after her second surgery, a total hip replacement, the only evidence of restrictions are contained in the report from Dr. Lieber. The Arbitrator is unable to determine from the evidence whether those restrictions would prevent the Petitioner pursuing the duties of her usual and customary line of employment. Accordingly, the Petitioner has not established entitlement to an award under Section 8 (d) (2) of the Act, which refers to individuals partially incapacitated from pursuing their usual line of employment.

Petitioner furthers argues that the award should still be made under the above section, and relies on the Appellate Court's decision in Will County as authority. Will County Forest Preserve District v. The Illinois Workers Compensation Commission, 97 N.E.2d 16 (2012).

In that decision, the Court ruled that shoulder injuries should not be compensated as arm injuries for basically two reasons, neither of which are present in this case. First of all, the injuries in that case involved the rotator cuff, the labrum and the acromion. The Court said that those parts of the body were part of the shoulder capsule, as opposed to the arm. Here, the Petitioner's injuries were to the femoral neck which is part of the leg. The only involvement with areas other than the leg came through the hip replacement surgery which included replacement the acetabulum, which is part of the illium.

Second, and more importantly, the petitioner in Will County complained of residual weakness, stiffness and pain in his shoulder as opposed to his arm. Here, the Petitioner's limitations and complaints were of weakness and pain in the right thigh and leg. The Appellate Court found the areas of the body with residual symptoms significant in determining the part of the body to be used for compensation purposes.

The Arbitrator thus feels the award should be made under Section 8 (e) of the Act. The Commission has provided opinions which serve as precedent for such an award. In Fenton v. Gardner Denver, 12 IWCC 1366, the Commission affirmed a decision of Arbitrator White awarding 60 % loss of a leg for a petitioner with a fractured femoral neck, treated first by an ORIF procedure, and later by a total hip replacement. In Beller v. Regency Nursing Care Residences, 11 IWCC 606, an award of 60 % of a leg by Arbitrator Tobin was also affirmed. The case involved a petitioner with a total hip replacement followed by residuals of weather related symptoms, strength decrease and problems standing for long periods of time.

I find the Petitioner to have been credible with respect to her testimony concerning her limitations. Her testimony was corroborated by that of her husband, and more importantly, by the objective findings contained in Dr. Lieber's examination.

The Petitioner is entitled to 60 % loss of use of her right leg. The Respondent is entitled to credit for the $5000.00 previously advanced against permanency.

Medical Bills

Petitioner presented what purports to be outstanding medical bills as Petitioner's Exhibit 11. However, upon further review, it is quite apparent the bills submitted by Petitioner are simply charges incurred throughout treatment for her various ailments and are not necessarily outstanding. After thorough review of Petitioner's exhibit, along with comparison of Respondent's Medical Bill Payment History (RX. 2) and Group Insurance Payment History (RX. 5), the Arbitrator finds the following:

Provider	Date of Service	Payment Status	Balance owed	Respondent Liability

Associated Anesthesiologists (296717)	12/27/2009	Paid	$0.0	None. Group coverage paid bill and balance is "balance billing"
Associated Anesthesiologists (306910)	10/3/2011	Paid	$0.0	None. Bill clearly reflects no balance is owed.
Central Illinois Pathology, SC	12/26/08 – 1/27/2009	Outstanding	$253.00	Yes. Respondent shall pay in full pursuant to the Illinois Workers' Compensation Fee Schedule.
Central Illinois Radiological Associates (2/19/11 bill)	12/26/08- 3/10/09	Paid	$0.0	None. Bill clearly reflects no balance is owed.
Central Illinois Radiological Associates (3/17/12 bill)	8/27/09-1/30/10	Paid	$0.0	None. Bill clearly reflects no balance is owed.
Central Illinois Radiological Associates (7/16/11 bill)	8/25/09-10/21/09	Paid	$0.0	None. Bill clearly reflects no balance is owed.
Central Illinois Radiological Associates (7/16/11 bill)	9/15/09-10/14/09	Paid	$0.0	None. Bill clearly reflects no balance is owed.
Central Illinois Radiological Associates (2/18/12 bill)	12/16/09-2/2/10	Paid	$0.0	None. Bill clearly reflects no balance is owed.
Central Illinois Radiological Associates (6/1/12 bill)	4/26/10-8/31/10	Paid	$0.0	None. Bill clearly reflects no balance is owed.
Central Illinois Radiological Associates (6/1/12 bill)	9/13/11-4/12/12	Paid	$0.0	None. Bill clearly reflects no balance is owed.
Central Illinois Radiological Associates (6/1/12	10/3/11-3/30/12	Paid	$0.0	None. Bill clearly reflects no balance is

bill)				owed.
Central Illinois Radiological Associates (6/1/12 bill)	12/2/11	Paid	$0.0	None. Bill clearly reflects no balance is owed.
Central Illinois Radiological Associates (6/11/12 bill)	6/20/11	Outstanding	$254.00	None. Bill reflects diagnosis for the outstanding charges is "chronic airway," which is not related to the hip injury at issue.
East Peoria Fire Department	12/26/2008	Outstanding	$344.00	None. Group coverage paid bill and balance appears to be "balance billing."
HeartCare Midwest	6/17/09 – 8/26/09	Outstanding	$653.64	None. Bill is clearly for Petitioner's pre-existing cardiac conditions to which the parties stipulated was not related to her 12/26/2008 injury.
Midwest Orthopedics	12/26/08-6/7/11	Paid	$0.0	None. Bill clearly reflects no balance is owed.
OSF St. Francis	12/26/08-12/30/08	Paid	Unknown	None. Petitioner submitted an itemized statement and not an outstanding bill. Respondent's exhibits indicate these charges have been paid in full through Petitioner's group health

				coverage (RX. 5).
OSF St. Francis	4/22/2010-4/28/2010	Outstanding	Unknown	None. The bill clearly appears to be for services completely unrelated to Petitioner's hip injury. Further no medical records were submitted to support the charges and allow the Arbitrator to determine whether they are related to Petitioner's hip injury.
OSF St. Francis	10/3/11/10/6/11	Outstanding	Unknown	RX. 2 and 5 indicate payments have been made to OSF for service on this date, but the outstanding amount is unclear. Respondent is ordered to pay any remaining charges for services provided to Petitioner by OSF from 10/3/2011-10/6/2011.
Saint Francis Home Health (3-9-2009 statement)	1/1/09-1/29/09	Outstanding	$35.00	None. Petitioner submitted a bill with "balance forward." The bill does not indicate what the service was for and there were

				no corresponding records admitted into evidence to support the charge for treatment.
Saint Francis Home Health	10/3/11-11/25/11	Paid	$0.0	None. RX. 2 indicates the charges for these dates of service have all been paid.
Wal-mart Pharmacy	Various	Paid	$0.0	None. Petitioner submitted an itemization of prescriptions Petitioner had filled. The itemization clearly indicates Petitioner has no amounts outstanding with Wal-Mart Pharmacy.

The Arbitrator notes Petitioner testified at trial that all of her related medical bills had been paid through Respondent. Petitioner simply submitted a list of original charges, without ascertaining what amounts are truly outstanding. Further, several of the bills submitted by Petitioner are clearly for services provided to Petitioner for her other pre-existing conditions, such as cardiac care. The parties stipulated the only injury at issue was Petitioner's hip injury and nothing else was related to Petitioner's December 26, 2008 accident. Accordingly, any bills for such treatment are denied. Respondent's Exhibits 2 and 5 indicate Respondent is entitled to a credit of $52,086.67 for amounts paid through the workers' compensation carrier and Petitioner's group health coverage. For amounts that remain outstanding and are chargeable to Respondent as outlined above, Respondent is ordered to issue payment to those providers in accordance with the Illinois Workers' Compensation Fee Schedule.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MICHAEL GRIFFIN,

Petitioner,

vs.

NO: 12 WC 44101

KOPPERS INDUSTRIES,

Respondent.

15IWCC0060

DECISION AND OPINION ON REVIEW

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

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission finds:

1. Petitioner had been employed by Respondent for 14 years as an Oiler at the time of the accident. He oils pumps and greases motors of various sizes. He works 5 days a week, 8 hours per day and spends all day on his feet.

2. On December 11, 2012 Petitioner was walking from one large compressor to another to check the fluids. In between the compressors are large aluminum pipes. Petitioner stooped down to pass through, but when he stood up the front of his safety helmet hit the pipe and pushed his head down into his neck. Petitioner became dizzy and had a queasy feeling in his stomach. He also developed a headache. He reported the incident to his supervisor and was instructed to call the triage nurse.

3. Petitioner completed his shift and went home. He had developed a tremendous headache by that time. He also had stiffness and soreness in his neck.

4. On December 14, 2012 Petitioner sought treatment from his family doctor, Dr. Smith. On December 17, 2012 Respondent sent Petitioner to Excel Rehab, the company clinic. There, he was provided medication and instructed to return to light duty work. He was instructed to file paperwork in the office. After 3 days, Excel Rehab continued light duty and prescribed physical therapy, which was agreed to by Dr. Smith.

5. Petitioner was diagnosed with a cervical strain and fatigue concussion.

6. On December 21, 2012 Dr. Smith took Petitioner off of work for 2 weeks. Petitioner presented the off work slip to Respondent and went home. Later that day he received a call from Respondent's superintendent asking if he could return to work because their lost time accident record was really good. He wanted Petitioner to be a team player. Petitioner agreed and returned to work, but was placed on full duty.

7. After returning to work Petitioner noticed that his pain was worsening.

8. Physical therapy helped Petitioner's pain, however, and on February 5, 2013 Dr. Smith released Petitioner to full duty. Nevertheless, Petitioner testified that he was still enduring 2-3 headaches per week, as well as neck stiffness, soreness and swelling. Petitioner has worked full duty ever since. He takes low dose aspirin for the pain, and also rubs methanol gel on his neck 2-3 times per week.

9. During an Independent Medical Examination (IME) performed by Dr. Bernstein on September 16, 2013, Petitioner indicated that he still suffers from minor stiffness and soreness in the back of his neck every morning.

The issues of accident, causal connection, medical expenses are not on review, and are thus affirmed by the Commission.

The Commission, however, modifies the Arbitrator's ruling on permanent partial disability. There are five factors that must be considered in determining any permanent partial disability award. The factors are:

1) AMA Impairment Rating;
2) Occupation of injured employee;
3) Age of the employee at time of injury;
4) Employee's future earning capacity; and
5) Evidence of Disability corroborated by medical records.

In the case at bar, no AMA Impairment Rating was submitted into evidence by either party. Petitioner continues to work full duty as an Oiler, which requires him to stoop, bend, twist and turn his head continuously. Petitioner was 55 years old at the time of injury. He has returned to his pre-injury employment. Lastly, his complaints during the IME were not disputed

15IWCC0060

by Dr. Bernstein, and the complaints persisted through the date of trial.

Based on the analysis of these five factors, the Commission views the evidence slightly different than the Arbitrator. The current and continuous complaints of Petitioner, both at trial and in the medical records, indicate that there is some permanent disability that Petitioner suffers from. Taking in conjunction with the other factors that are considered when determining permanent partial disability, the Commission finds that Petitioner should be awarded a 2.5% loss of his person as a whole due to his cervical strain and ongoing complaints.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner is entitled to 12.5 weeks of permanent partial disability benefits at $587.28 per week, as he suffered a 2.5% loss of use of his person as a whole under §8(d)(2) of the Act. The total amount of permanent partial disability benefits equals $7,341.00.

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 $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: JAN 23 2015
O: 11/20/14
DLG/wde
45

David L. Gore

Mario Basurto

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

GRIFFIN, MICHAEL
Employee/Petitioner

Case# **12WC044101**

KOPPERS INDUSTRIES
Employer/Respondent

15IWCC0060

On 7/1/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.06% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0311 KOSIN LAW OFFICE LTD
DAVID X KOSIN
134 N LASALLE ST SUITE 1340
CHICAGO, IL 60602

0507 RUSIN MACIOROWSKI & FRIEDMAN LTD
DANIEL R EGAN
10 S RIVERSIDE PLZ SUITE 1530
CHICAGO, IL 60606

15IWCC0060

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

Michael Griffin
Employee/Petitioner

v.

Koppers Industries
Employer/Respondent

Case # **12** WC **44101**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Deborah L. Simpson**, Arbitrator of the Commission, in the city of **Chicago**, on **November 27, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

15IWCC0060

On **December 11, 2012**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**50,897.60**; the average weekly wage was $**978.80**.

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

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

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

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

Respondent is entitled to a credit of $**210.00** under Section 8(j) of the Act.

ORDER

Medical benefits

Respondent shall pay Petitioner reasonable and necessary medical services of $60.00, as provided in Section 8(a) of the Act. Respondent shall pay to the providers reasonable and necessary medical services, pursuant to the medical fee schedule, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay to the providers reasonable and necessary medical services as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall be given a credit of $210.00 for medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Permanent Partial Disability

Petitioner has failed to prove entitlement to permanent partial disability benefits. Claim for permanent partial disability benefits is denied.

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

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

Deborah L. Simpson
Signature of Arbitrator

July 1, 2014
Date

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JUL 1 - 2014

15IWCC0060

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Michael Griffin,	)	
	)	
Petitioner,	)	
	)	
v.	)	No. **12 WC 44101**
	)	
Koppers Industries,	)	
	)	
Respondent.	)	

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

The parties agree that on December 11, 2012, the Petitioner and the Respondent were operating under the Illinois Workers' Compensation or Occupational Diseases Act and their relationship was one of employee and employer. On that date the Petitioner sustained an accidental injury or was last exposed to an occupational disease that arose out of and in the course of the employment. They further agree that the Petitioner gave the Respondent notice of the accident within the time limits stated in the Act.

At issue in this hearing is as follows: (1) is the Petitioner's current condition of ill-being causally connected to this injury or exposure; (2) 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; and (3) the nature and extent of the injury.

STATEMENT OF FACTS

The Petitioner testified that he has been employed by the Respondent for approximately 14 years, since June 21, 1999. He described his job as an "oiler." He testified that he works with pumps of various sizes, greases motors and checks fuel levels. He testified that his job is five days per week, eight hours per day, and that he is on his feet during this time. He is required to wear a hard hat that weighs less than 10 lbs., and safety goggles. His job requires him to be able to look up and down, and to the left and right while wearing this safety gear. He testified this job requires him to perform some lifting in order to maintain the machines.

The Petitioner testified that on December 11, 2012, while in this position, he was required to move between machines. There was an aluminum pipe about four to five feet off the ground. Petitioner testified that he bent over to pass beneath this pipe, and he stood up too soon, striking the front of his hard hat against this pipe. In turn the hard hat struck is forehead. Petitioner testified that his head went backward and he felt like he was going to pass out. He began to experience a severe headache across the front of his head where his hard hat was. Petitioner testified that in time he began to feel sore.

The Petitioner testified that he spoke by telephone with a "triage nurse." He explained that felt bad; that his head hurt and his neck was sore and stiff.

On Friday, December 14, 2012, Petitioner presented for medical care with his primary care physician at Anointed Health Partners, Ltd (Px 1). He reported having hit his head at work. He reported losing no time from work. He was diagnosed as having a headache and a cervical strain.

On Monday, December 17, 2012, Petitioner went to the Respondent's occupational health clinic, Excel Occupational Health Clinic (Px 2). Here he again reported having hit his head on a pipe at work. He indicated he did not feel immediate pain, but began to feel it a few hours later. He described the pain has being on the left side of his forehead down to the left side (backside) of his head. He indicated he felt very tired. He indicated that ibuprofen helped. He was diagnosed as having a cervical strain and fatigue – concussion vs. diarrhea. He was given a prescription for a Medrol Dose Pack. He was not kept off work (Px 2).

On Thursday, December 20, 2012, Petitioner returned to Excel (Px 2). He continued to complain of neck pain as well as headache. He was offered trigger point injections into his neck which he declined. He received a referral for physical therapy. He was allowed to continue working in a light capacity (Px 2).

On Friday, December 21, 2012, Petitioner returned to his primary care physician at Anointed Health Partners. The record does not reflect any complaint of headache, only of neck pain (Px 1).

The Petitioner testified he lost no time from work. Petitioner testified that he performed his regular work activities after a couple days of light duty.

The Petitioner received physical therapy during the month of January 2013 at Maximum Rehabilitation Services (Px 3). On January 30, 2013, Petitioner was discharged from therapy, having met all goals.

On Tuesday, February 5, 2013, Petitioner saw his primary care provider (Px 1). The record reflects that Petitioner was better, and was working overtime. He was status post cervical strain.

The records from Anointed Health Partners reflect Petitioner was seen on Friday, March 22, 2013. This was for a blood pressure check up. There is no notation as to any neck pain or headache (Px 1).

Petitioner testified that he did not receive any MRI but that he did have x-rays performed in this matter.

Petitioner testified that he continues to perform his same job for Respondent. He has no expectation of losing his employment in the foreseeable future. He acknowledged that he has access to medical assistance for his condition if he required same.

At the Respondent's request, Petitioner saw Dr. Avi Bernstein (Rx 3). Dr. Bernstein's report reflects that Petitioner denied any significant residual symptoms.

Dr. Bernstein examined the Petitioner. Dr. Bernstein concluded that Petitioner's exam was entirely benign. Dr. Bernstein reviewed Petitioner's medical records. He concluded that the treatment that Petitioner received was reasonable and necessary and causally related to the work incident. Dr. Bernstein further concluded that Petitioner had not suffered a permanent injury (Rx 3).

CONCLUSIONS OF LAW

The burden is upon the party seeking an award to prove by a preponderance of the credible evidence the elements of his claim. *Peoria County Nursing Home v. Industrial Commission,* 115 Ill.2d 524 91987). This includes the nature and extent of the petitioner's injury.

For treatment of an employee's workplace injury to be compensable under workers' compensation laws, Petitioner must establish the treatment is necessitated by the work injury and not some other cause or condition. *Hansel & Gretel Day Care Center v Industrial Commission,* (1991) 215 Ill.App.3d 284, 574 N.E.2d 1244.

In determining the level of permanent partial disability for injuries that occur on or after September 1, 2011, the Commission shall base its determination on the following factors: (i) the reported level of impairment pursuant to subsection (a); (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; (v) evidence of disability corroborated by the treating medical records. No single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order (820 ILCS 305/8.1b).

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

The Arbitrator finds Petitioner's condition at the time of trial is causally related to the alleged accident of December 11, 2012. Petitioner denied any prior condition of ill-being with respect to his head or neck. All of the medical evidence herein supports that Petitioner sustained an accidental injury, for which he has received appropriate medical care.

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?

Based upon the Arbitrator's findings above, the Arbitrator awards the petitioner medical bills in the amount of $3,454.00 as itemized in Px4.

EXHIBIT	PROVIDER	CHARGES
1	Anointed Health Partners, Ltd. (Only the DOS: 12/14/12, 12/21/12 and 2/5/13)	$270.00
2	Excel Occupational Health Clinic	$682.00
3	Maximum Rehabilitation Services, Ltd.	$2,502.00
	Grand Total:	$3,454.00

The Arbitrator notes the stipulation of the parties that should any medical bill be awarded herein, the bill shall be paid in conformity with the prevailing Medical Fee Schedule amount as required by the Act. The parties further agree that payment shall be made directly to the provider subject to any previous payments or 8(j) credit the respondent can establish.

Rx1 is a compilation of medical payments made by the workers' compensation carrier.

Rx2 is a compilation of medical bills paid through petitioner's BC/BS policy for which the respondent is entitled to a credit pursuant to §8(j) for treatment with Anointed Health Partners.

Respondent has stipulated on the record that, should the medical bills be awarded, the Respondent will reimburse the petitioner for co-pays in the amount of $60.00, as listed in Rx 2.

What is the nature and extent of the injury?

The Arbitrator adopts by reference all prior findings and conclusions into this Section without restating them herein. This claim arose after September 1, 2011; therefore the five factors for determining Permanent Partial Disability shall be applied here. The Arbitrator notes the five factors to determine Permanent Partial Disability are: 1) AMA Impairment Rating; 2) Occupation of the injured employee; 3) Age of the

employee at the time of the injury; 4) Employee's future earning capacity and 5) Evidence of disability corroborated by the treating medical records. No one factor shall be controlling but a written explanation is required if an award is greater than the AMA Impairment Rating. 820 ILCS 305/8.1b(b).

It is the Petitioner's burden to prove all aspects of his claim for benefits. This includes entitlement to Permanent Partial Disability.

AMA Impairment Rating: Neither side offered into evidence an AMA Impairment Rating *per se*; however, Respondent submitted into evidence a report from Dr. Bernstein, which reflects, *inter alia*, that Petitioner "has not suffered a permanent injury" (Rx 3). The Arbitrator infers that if there is no permanent injury, there is no impairment pursuant to AMA requirements, and thus a zero impairment rating.

Occupation of the Injured Employee: The Petitioner testified his job title is that of an "oiler." He testified that he works with pumps of various sizes, greases motors and checks fuel levels. He testified that his job is five days per week, eight hours per day, and that he is on his feet during this time. He is required to wear a hard hat that weighs less than 10 lbs., and safety goggles. His job requires him to be able to look up and down, and to the left and right while wearing this safety gear. He testified this job requires him to perform some lifting in order to maintain the machines.

Age of the Injured Employee at Time of Accident: The Petitioner was 55 years old at the time of the accident.

Employee's Future Earning Capacity: Petitioner testified he has returned to the position he held prior to the injury. He is able to perform his job duties, full time, with no restrictions. He returned to the same job, working with the same materials, working the same hours, with the same job title and rate of pay. He testified he works varying shifts, and the medical records (Px 1) reflect he works overtime when offered. Petitioner's future earning capacity has not been affected by the accidental injury.

Evidence of Disability corroborated by the treating medical records: Petitioner testified that he still has headaches. He testified that he has a stiff and sore neck in the morning for which he takes a low dose aspirin. He uses a menthol heat cream. Petitioner acknowledged that these were not prescribed by a doctor, and in fact do not appear in the treating doctors medical records. These ongoing complaints do not appear in the medical records. Petitioner testified that the base of his skull still swells; this is not reflected in the medical records either.

Given the nature of the injury that Petitioner suffered, and the lack of any permanent injury as noted by Dr. Bernstein, the Petitioner failed to prove that he sustained any Permanent Partial Disability as a result of the December 11, 2012 accidental injury.

ORDER OF THE ARBITRATOR

Petitioner is entitled to $60.00 for his out of pocket co pays as demonstrated in the Blue Cross & Blue Shield records (Rx 2).

Petitioner failed to prove he sustained any Permanent Partial Disability. Petitioner's claim for Permanent Partial Disability is denied.

Respondent to pay the petitioner's medical bills in the amount of $3,454.00 as itemized in Px4, pursuant to the fee schedule as provided in the Act.

Richard L. Simpson
Signature of Arbitrator

July 1, 2014
Date

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Darell Earhart,
Petitioner,
vs.
Cassens Transport,
Respondent,

NO: 12 WC 31747

15IWCC0061

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 what is the nature and extent of the petitioner's permanent partial disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 12, 2014 is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $14,300.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JAN 2 3 2015

MB/mam
o:1/15/15
43

Mario Basurto

David L. Gore

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

EARHART, DARELL
Employee/Petitioner

Case# **12WC031747**

15IWCC0061

CASSENS TRANSPORT
Employer/Respondent

On 6/12/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.06% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0787 MEYERS & FLOWERS LLC
JOHN HARP III
3 N 2ND ST SUITE 300
ST CHARLES, IL 60174

2396 KNAPP OHL & GREEN
ETHAN J WILLENBORG
6100 CENTER GROVE RD
EDWARDSVILLE, IL 62025

15IWCC0061

☐ Injured Workers' Benefit Fund (§4(d))

☐ Rate Adjustment Fund (§8(g))

☐ Second Injury Fund (§8(e)18)

☒ None of the above

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

ILLINOIS WORKERS' COMPENSATION COMMISSION

ARBITRATION DECISION

Darell Earhart

Employee/Petitioner

v.

Cassens Transport

Employer/Respondent

Case # 12 WC 31747

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 KETKI STEFFEN, Arbitrator of the Commission, in the city of **CHICAGO**, on **May 9, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

B. ☐ Was there an employee-employer relationship?

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

D. ☐ What was the date of the accident?

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

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

G. ☐ What were Petitioner's earnings?

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

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

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

K. ☐ 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 _____

15IWCC0061

FINDINGS

On **July 4, 2012**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $83,497.96; the average weekly wage was **$1,605.73.**

On the date of accident, Petitioner was **47** years of age, single with 1 dependent children.

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

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

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

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

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of $ 712.55/week for 20 weeks, because the injuries sustained caused the 4% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

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

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

Kethi Steffen — 6.12.14

Signature of Arbitrator — Date

JUN 12 2014

ICArbDec p. 2

PROCEDURAL HISTORY

This matter was presented for a hearing on the merits before Arbitrator Ketki Steffen on May 8, 2014. Both parties were represented by counsel and have entered into several stipulations that are contained as Arbitrator's Exhibit No. 1 ("AX1") for the trial record. The only disputed issue is nature and extent of the injuries. The accident occurred on 7/4/12 a date which post-dates the September, 2011 AMA guidelines amendment to the Act. Neither sides have submitted an AMA rating.

FACTUAL HISTORY

The Petitioner was 47 years old at the time of his work accident of July 4, 2012. He worked as semi-truck driver that transports cars for Respondent Cassens Transportation Company. Petitioner was engaged in his work duties on his semi when he started falling from the semi trailer. He tried to catch himself from falling by grabbing a ladder with his right arm and in the process suffered an injury to his right shoulder and arm. The accident occurred at Stoney Island Avenue in Chicago, Illinois.

After the work accident, Petitioner completed an accident report for Respondent where he noted arm pain and indicated the pain was in his right elbow area. (R.Ex.2). Petitioner testified that the pain was going through his whole body, including his shoulder, stomach and leg, but he did not indicate these areas of pain on the pain diagram. (Tr.28-29).

Two days after the work accident Petitioner sought medical treatment at Regional Occupational Healthcare Center ("ROCC") on July 6, 2012. The medical provider noted the following: "He reports 9 out of 10 burning pain, which is constant, but then later on

he tells me that the burning pain is intermittent and only occurs with certain movements." (P. Ex. 1) Petitioner was diagnosed with a right shoulder strain and neuropraxia. Petitioner was advised to take Ibuprofen 400 mg three times a day. No work restriction were place and the Petitioner returned to work full duty.

Petitioner followed up at ROCC on July 9, 2012. At that time, Petitioner complained of a burning pain from under his right arm down to his elbow. He was prescribed 40 mg of Prednisone for six days and Nucynta for pain control. Petitioner testified that he never took any Prednisone. (Tr.15).

On August 8, 2012, Petitioner was reevaluated at ROCC. Petitioner complained of continued pain and numbness in his right upper arm but the tingling had improved. The medical provider noted, "He did ride his motorcycle 532 miles and indicated that this irritated his arm some." (P.Ex.1). Petitioner testified that this motorcycle mileage came from a vacation due to being laid off at that time. (Tr.30-31 Petitioner denied that the motorcycle riding irritates his arm. He testified that "doing hard physical work" irritated his arm. (Tr.31-32)

Dr. Michael Krauss of ROCC examined Petitioner on September 12, 2012. He noted that that Petitioner's right upper extremity pain had dramatically improved over the past two months. Petitioner only noticed pain with prolonged lifting with the arm elevated at 90 degrees. Petitioner had denied any numbness or tingling. Dr. Krauss diagnosed Petitioner with a brachial plexus injury of the right arm and recommended a follow-up in four to six weeks.

In September 17, 2012 Petitioner had an unrelated injury to his right ankle. (T.19 He was first evaluated at ROCC for his right ankle on September 24, 2012.

Petitioner claims that he told the medical provider at ROCC about continued right upper extremity symptoms when he was evaluated on September 24, October 2, 9, and 22, and November 12 of 2014. (Tr.33-34). The medical provider did not note any of these continued complaints in his medical records. (P.Ex.1).

On December 10, 2012 underwent a medical examination at ROCC. At that time, Dr. Krauss noted that Petitioner complained of minimal symptoms in his right arm. Dr. Krauss noted in Petitioner's physical examination, "His right arm reveals full range of motion, excellent strength in all planes, no tenderness to palpation, [and] normal sensation throughout the upper extremity." (P.Ex.1). Petitioner had several follow-up appointments at ROCC through March 27, 2013.

Petitioner testified that he currently experiences burning, throbbing, and weakness in his right elbow, arm, and shoulder. He denies any loss of strength in his right upper extremity. (Tr.19). Petitioner acknowledged that in a Department of Transportation ("DOT") physical at ROCC on June 20, 2013 he claims to have no physical limitations. (R.Ex.5). He passed the DOT physical and was given a Medical Examiner's Certificate scheduled to expire on June 20, 2015.

FINDINGS/ANALYSIS

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

Accident, notice, causation and medicals are not in dispute. Petitioner was 47 years old when he suffered an injury to his right upper extremity after slipping off his

truck and grabbing a ladder with his right hand. Two days after the work accident Petitioner sought medical treatment ROCC and was diagnosed with a right shoulder strain and neuropraxia. Petitioner was never restricted from his work duties and was allowed to work full duty but claims that he currently experiences burning, throbbing, and weakness in his right elbow, arm, and shoulder. A August 8, 2012, medical note from ROCC notes that Petitioner complained of continued pain and numbness in his right upper arm but the tingling has improved his condition. The Petitioner was treated conservatively and he passed the DOT physical and was given a Medical Examiner's Certificate scheduled to expire on June 20, 2015. Neither sides have submitted an AMA rating and the Respondent has proposed that there is no permanency.

As this case post-dates the September 1, 2011 amendment of Worker's Compensation Act ("Act") the Arbitrator has, pursuant to §8.1b of the Act, considered the following criteria and factors in determining the level of permanent partial disability.

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

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

(i) the reported level of impairment pursuant to subsection (a);

(ii) the occupation of the injured employee;

(iii) the age of the employee at the time of the injury;

(iv) the employee's future earning capacity; and

(v) evidence of disability corroborated by the treating medical records. No single enumerated factor shall be the sole determinant of disability. In determining the

level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order.

Based on the record as a whole, and as explained in detail above, the Arbitrator finds that Petitioner has established permanent partial disability to the extent of 4 % loss of use of the person as a whole pursuant to Section 8(d)(2). *Will County Forest Preserve District v. IWCC*, 2012 Ill.App. This finding is based in part on the fact that Petitioner was credible and clear in his testimony and that his testimony regarding his injury is supported by medical evidence. Although Petitioner has not suffered any loss of income, the Petitioner continues to suffer burning, throbbing, and weakness in his right elbow, arm, and shoulder.

Ketki Steffen
Arbitrator Ketki Steffen

6.12.14
Date

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Joseph Williams,
Petitioner,

vs.

NO. 12 WC 10526

15IWCC0062

Advocate South Suburban Hospital,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by Petitioner and Respondent herein and notice given to all parties, the Commission, after considering, Petitioner's issues of causal connection, prospective medical expenses, temporary total disability and penalties and attorneys' fees and Respondent's issues of accident and 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 on March 24, 2014 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.

15IWCC0062

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $33,400.00. 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: JAN 2 3 2015

Daniel R. Donohoo

Charles J. DeVriendt

Ruth W. White

o-01/13/15
drd/wj
68

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

WILLIAMS, JOSEPH
Employee/Petitioner

Case# **12WC010526**

10WC045017
10WC045016

ADVOCATE SOUTH SURBURBAN HOSPITAL
Employer/Respondent

15IWCC0062

On 3/20/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0391 THE HEALY LAW FIRM
DAVID HUBER
111 W WASHINGTON ST SUITE 1425
CHICAGO, IL 60602

1109 GAROFALO SCHREIBER & HART ET AL
TODD WEGMAN
55 W WACKER DR 10TH 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
19(b)

Joseph Williams
Employee/Petitioner

v.

Advocate South Suburban Hospital
Employer/Respondent

Case # 12 WC 10526

Consolidated cases:
10WC45016 10WC45017

15IWCC0062

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Brian Cronin**, Arbitrator of the Commission, in the city of **Chicago**, on **8-15-2013** and **10-24-2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **3-7-2012**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding each of the injuries, Petitioner earned **$50,845.60**; the average weekly wage was **$977.80**.

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

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

Respondent, shall be given a credit of **$15,737.91** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$0.00** for other benefits, for a total credit of **$15,737.91**.

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 commencing **3-8-2012** through **8-15-2013**, or **75-1/7** weeks, at a rate of **$651.87**/week, pursuant to Section 8(b) of the Act.

Respondent shall pay Petitioner for the following medical bills, pursuant to Section 8(a) and subject to Section 8.2 of the Act: Advocate Medical Group (PX5), $1,513.00; Advocate South Suburban Hospital (PX4), $15,427.00; Hinsdale Orthopaedics (PX6), $511.00; Injured Workers Pharmacy (PX9), $5,037.96. Respondent is entitled to a credit for medical bills previously paid.

Respondent shall authorize and pay for the prospective medical care that Michael Zindrick, M.D., has prescribed, which includes an L4-5 laminectomy and fusion with cages and internal fixation, diskectomy and nerve decompression, as well as a back brace, physical therapy and work conditioning (Pet. Ex. 8, pp. 16-17), pursuant to Section 8(a) and subject to Section 8.2 of the Act.

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

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

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

before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of Arbitrator

March 18, 2014
Date

ICArbDec19(b)

MAR 20 2014

ILLINOIS WORKERS' COMPENSATION COMMISSION OF ILLINOIS

Joseph Williams, Petitioner, v.	)	Case No. 12 WC 10526
	)	Consolidated w/ 10 WC 45016
	)	10 WC 45017
Advocate South Suburban Hospital, and HCR Manor Care, Respondents,	)	15IWCC0062

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT:

Petitioner is a fifty-three-year-old, right-handed male who started working for HCR Manor Care in 2010 as Director of Environmental Services/Laundry. (Tr.15-16)

His job duties for HCR Manor Care involved supervising eleven people, including floor care technicians and individuals in the laundry department. (Tr.16-17)

On June 1, 2010, Petitioner saw Dr. Sachin Dixit. Petitioner reported having low back pain since last week when he was moving things at work. He indicated that he could not bend, dress up, and felt very stiff when he walked. The pain radiated down his right leg. Dr. Dixit instructed Petitioner to perform activity as tolerated. (PX2, pp. 63-65)

On June 8, 2010, Petitioner again saw Dr. Dixit in follow up for his back pain. Petitioner indicated that he had been taking his medication, which was helping with his pain. While he was able to do his daily activities, he was still limited. Again, Dr. Dixit directed Petitioner to perform activity as tolerated. (SSH4, pp. 49-51)

On July 29, 2010, Petitioner was working for HCR Manor Care. Petitioner testified that when he arrived at work on July 29, 2010, his back was "fine." Petitioner testified that his job

duties that day included moving an old wooden wheelchair full of wheelchair legs and various other heavy items. Petitioner further testified that he was in the process of pulling a wheelchair into a storage pod when he heard a "pop" in his lower back. At that time, Petitioner continued, he felt a sharp pain and started perspiring. (Tr.19-20).

Petitioner worked for the remainder of the day on July 29, 2010, then he went to the emergency room at Advocate South Suburban Hospital. (Tr.20).

He followed up with Dr. Dixit on July 29, 2010. (PX2, pp .157-159)

Dr. Dixit sent him for a lumbar spine MRI, which was carried out on August 12, 2010. (PX2, pp. 228-229)

Petitioner continued under the care of Dr. Dixit and was given work restrictions. (PX2, p. 359; p.154; p.358)

He also participated in physical therapy. (SSH4, p. 67)

Petitioner continued to receive treatment with Dr. Dixit and was in physical therapy. He still elicited complaints of back pain to Dr. Dixit and was kept on work restrictions. (PX2, pp.145 & 365)

On October 29, 2010, Petitioner was working for HCR Manor Care. His job duties that day included moving furniture. (Tr.23-24). On that date, after he moved furniture, he felt worsening back pain. He testified that he was treated in the emergency room at Advocate South Suburban Hospital and referred to his primary care physician. (Tr.24-25).

Petitioner saw Dr. Dixit again on November 2, 2010. Dr. Dixit's history reflects that Petitioner, while on work restrictions, had to move three nightstands, a dresser, and a bed all on the same day at work. Since then, Petitioner claimed he had aggravations of his lower back pain. He rated the pain at 10 out of 10. He was also complained of tingling in his left leg and left foot.

The treatment included physical therapy, a TENS unit, and Hydrocodone. (PX2, pp. 142-144)

Petitioner was taken off work and sent for physical therapy. (PX2, p. 42; p. 361; p. 355; SSH4, pp. 80-84)

Petitioner was off work between November 3, 2010 and December 8, 2010, during which time HCR Manor Care paid him TTD benefits. (Tr. 27-28)

On December 6, 2010, at the request of HCR Manor Care, and pursuant to Section 12 of the Act, Dr. Michael Kornblatt evaluated Petitioner. Dr. Kornblatt's opinion was that Petitioner had sustained a lumbosacral strain as a result of his accident while working for HCR Manor Care in July 2010. He further opined that such strain would have resolved approximately eight to twelve weeks post injury. Dr. Kornblatt determined that Petitioner had lumbar degenerative disc disease at two levels, and that this condition pre-existed his lumbosacral strain. He stated that Petitioner could return to work with restrictions of no lifting more than twenty pounds for four weeks, followed by a full-duty return to work. (SSH6)

Petitioner testified that his symptoms got better to the point where he could go back to work with a full-duty release. (Tr.29) However, Dr. Dixit's November 29, 2010 chart note confirms that he recommended continued physical therapy and the use of a TENS unit. Dr. Dixit also authorized Petitioner off work until he completed his physical therapy. (PX2, pp. 136-138)

In January 2011, Petitioner left the employ of HCR Manor Care. (Tr. 30)

Petitioner continued to receive medical treatment for his lumbar condition.

On January 15, 2011, he saw Dr. Dixit and provided a history of having to go to a meeting and sit for three hours, which he found to be very uncomfortable. Petitioner's pain was getting worse even after therapy and with pain medication. He rated his pain at 8 out of 10 and indicated that it radiated into his left leg. The treatment plan included taking a Medrol Dosepak

until he sees a pain specialist. Dr. Dixit also recommended consideration of surgery if the injections do not work. (PX2, pp. 130-132)

Dr. Meghan Rhodes saw Petitioner on January 25, 2011. Dr. Rhodes recommended an epidural steroid injection. She wrote that if he did not respond to that, she would recommend a trial of neuropathic pain agents. Another option she would consider would be discography in order to determine if a posterior annular tear was responsible for his pain. (PX2, pp. 32-33)

On February 12, 2011, Dr. Dixit saw Petitioner in follow up for his back condition. Dr. Dixit noted that a pain specialist was recommending epidural steroid injections, and Petitioner was awaiting authorization. His history reflects that Petitioner did not go to work the prior day due to pain; he was still having left-sided pain in the hip area. Dr. Dixit recommended a continuation of the pain medications. (PX2, pp. 127-129)

In March 2011, Petitioner began working for Advocate South Suburban Hospital as an Environmental Services Supervisor. (Tr. 30-31)

Petitioner continued to receive treatment for his back with Dr. Dixit. Dr. Dixit saw him on March 22, 2011, for continued complaints of low back pain. (PX2, pp.121-123)

Dr. Rhodes administered an epidural steroid injection to Petitioner on March 24, 2011 and Dr. Shailesh Ghandi administered another one on May 24, 2011. (PX2, pp. 254-255)

After receiving the two injections, Petitioner saw Dr. Dixit on June 3, 2011. Petitioner rated his back pain at 4 or 5 out of 10, instead of 8 out of 10. (PX2, pp. 114-117)

On June 21, 2011, Dr. Gandhi administered another epidural steroid injection to Petitioner. (PX.2, p. 253)

He then returned to see Dr. Dixit on July 5, 2011 and continued to complain of low back pain. He was taking Hydrocodone for pain as well as Lyrica. Dr. Dixit recommended

Prednisone for seven days, as well as the present management. (PX2, pp. 111-113)

Petitioner saw Dr. Dixit again on September 23, 2011 and complained of mid-back pain, lower back pain and an inability to sleep due to back stiffness. An MRI had not yet been approved by workers' compensation. Dr. Dixit recommended that he take Percocet and increase his use of Lyrica. (PX2, pp. 108-110)

On October 11, 2011, pursuant to Section 12 of the Act, HCR Manor Care sent Petitioner to be evaluated by Dr. Wesley Yapor. Petitioner complained to Dr. Yapor of back pain with radicular symptoms. Dr. Yapor's impression was that Petitioner had L4-5 and L5-S1 degenerative disc disease, which pre-dated his injuries of July 29, 2010 and October 29, 2010. However, he stated that on both of those occasions, Petitioner exacerbated his condition by his lifting activity. He stated that prior to these two incidents, Petitioner never missed work and did not attend physical therapy. Thus, he concluded that Petitioner's condition was clearly related to both injuries. He recommended a lumbar discogram, potentially followed by a two-level lumbar fusion. He stated that requiring Petitioner to return to full-duty work at this time would place him at risk of further injury. (SSH5)

Petitioner continued under the care of Dr. Dixit. (PX2, pp. 101-104) He also continued to receive pain management with Dr. Gandhi. (PX2, pp. 251-252)

Petitioner was sent for another MRI of his lumbar spine, which was carried out on November 22, 2011. (PX2, pp. 219-220)

On December 2, 2011, Dr. Ghandi injected Petitioner with an epidural steroid at L4-5. (PX2, p. 250)

Petitioner returned to Dr. Dixit on February 7, 2012 with complaints of back pain. Petitioner sought a referral for epidural injections to be given by a pain management physician.

Dr. Dixit wrote: "injections in the back helped him a lot and he forgot he had an injury." He was still receiving pain management, applying a Butrans pain patch and taking Oxycodone periodically. (PX2, pp. 98-100)

On March 7, 2012, Petitioner was performing his duties as an Environmental Services Supervisor for Advocate South Suburban Hospital. Petitioner testified that, on that date, a trash chute was overflowing with trash. This trash chute was in an area that was visible to visitors and patients. Petitioner testified that he pulled 8 to 10 bags of trash that weighed approximately 10 to 14 pounds. He had to lift the bags off the floor and toss them four to five feet into a gondola. (Tr. 36-37) While he was performing this activity, Petitioner testified, he started to have some discomfort in his back. He then got on an elevator to go downstairs, at which time his pain got worse. When he got to the basement, he felt severe pain. Due to the pain, he had to hold onto a handrail while he proceeded to walk down a hallway. Petitioner testified that he then blacked out and needed to be helped off the floor. Petitioner provided unrebutted testimony that two employees asked him if he was okay, placed him in a desk chair with casters, wheeled him to the office, then transferred him to a wheelchair and took him to the emergency room at Advocate South Suburban Hospital. (Tr. 37-40) At first the staff thought he had had suffered a stroke.

Petitioner testified that as compared with his back symptoms in 2010, his back pain on March 7, 2012 was totally different: excruciating pain that led him to black out. (Tr. 42) When asked if it was the magnitude of the pain or the character of the pain that was different, Petitioner testified that it was the magnitude of the pain. (Tr. 42)

Petitioner was then admitted to Advocate South Suburban Hospital. The earliest history taken (PX1, p. 5), March 8, 2012 @ 01:20, states:

"gentlemen is 52-year-old male, who presents for evaluation of left lower sternum the weakness (sic). Patient has had history of chronic back pain and states he had an MRI in the past done that showed some possible bulging disc or nerve compression. Today it got much worse. He said 'leg weakness which is new. No bowel or bladder continence. He is the left upper trauma he weakness (sic). No facial droop. No slurred speech."

A history taken at Advocate South Suburban Hospital on March 8, 2012 @ 01:54 states:

"Tonight approx 2130 at work c/o lower lumbar pain to back, left leg became weak, numb and tingling and unable to maintain weight/unsteady gait and pt dropped to the floor. Hx of L4-L5 problems." (PX1, p. 5)

An Advocate South Suburban Hospital emergency department nursing summary set forth that Petitioner reported that he was walking down the hall and his left leg just gave out. (PX1, pp. 16, 18, 20) In the hospital, he underwent a lumbar spine MRI and CT scan. (PX1, pp. 7-8; 57-58)

While in the hospital, Petitioner was evaluated by Dr. Chinnammal Kandaswamy. Dr. Kandaswamy performed a history and physical on March 8, 2012. Petitioner's history included ongoing back problems. He was doing well following an epidural steroid injection. On the day prior, Petitioner felt acute pain in his lower back shooting down to his left lower extremity. His legs gave way, and he fell down. (PX1, p. 132)

While in the hospital on March 8, 2012, Petitioner was also evaluated by Dr. Anil Kesani. Dr. Kesani took a history from Petitioner. Such history indicated that Petitioner has had problems with his lower back for approximately 2 years. He initially injured his back at work 2 years prior. His pain was constant until he obtained an epidural injection in December 2011, at

which time his pain subsided. He reported that he subsequently re-injured his back approximately 3 weeks prior at which time he developed mechanical low back pain, and left lower extremity radiating pain with numbness and tingling the next day. Petitioner reported that over the last 3 weeks, his symptoms progressively worsened. He has no right lower extremity radiating pain. In terms of the left lower extremity radiating pain, it is sporadic. He reports that the left lower extremity pain worsens with standing and especially walking. It is relieved by sitting. Overall, he reports that his low back pain is much worse than his left lower extremity radiating pain. It is 85% back pain and 15% leg pain. It is the back pain that prevents him from working, recreational activities and household tasks. It is the back pain that necessitated a hospital admission. (PX1, pp. 128-129)

While he was hospitalized, Petitioner received another epidural steroid injection, which was administered by Dr. Ghandi. (PX2, p. 14)

Dr. Kandaswamy also generated a discharge summary that is dated March 10, 2012. The history set forth that Petitioner had been admitted with an acute episode of excruciating pain and falling down at work. (PX1, p. 131)

Petitioner thereafter continued under the care of Dr. Dixit. When Petitioner saw Dr. Dixit on March 12, 2012, Dr. Dixit took a history. Petitioner was at work on the Wednesday prior when he was having pain in his left leg and his left leg gave out. (PX2, pp. 95-97)

Petitioner continued under the care of Dr. Dixit. On March 20, 2012, Petitioner was released to return to work on April 2, 2012. (PX2, p. 345) On March 27, 2012 and April 10, 2012, Dr. Gandhi administered epidural steroid injections. (PX2, pp. 239 & 237)

On April 24, 2012, Dr. Gandhi administered another epidural steroid injection. (PX2, p. 235) On April 30, 2012, Dr. Dixit generated a note in which he authorized Petitioner to return to

work on May 14, 2012. (PX2, p. 343) On May 14, 2012, Dr. Dixit kept Petitioner off work until further notice. (PX2, p. 339)

Petitioner underwent an updated evaluation by Dr. Wesley Yapor on July 3, 2012. (SSH5, p. B13) Dr. Yapor reviewed an updated MRI and noted that it showed slight progression of Petitioner's L4-5 and L5-S1 disc disease. Dr. Yapor recommended an L4 to S1 decompression and fusion.

As noted earlier in FINDINGS OF FACT, Respondent HCR Manor Care previously engaged Dr. Wesley Yapor to examine Petitioner, pursuant to Section 12 of the Act.

Respondent HCR Manor Care subsequently made arrangements for Petitioner to be evaluated by Dr. Sean Salehi, pursuant to Section 12 of the Act. Dr. Salehi examined Petitioner on July 28, 2012. (HCR RX2) Dr. Salehi testified that Petitioner had a pre-existing condition in his lumbar spine. He testified that each of Petitioner's accidents exacerbated his pre-existing conditions, but that those exacerbations were temporary in nature. He opined that Petitioner would have reached maximum medical improvement within three months of each accident. (RX2, Dep. Tr., p. 25). Dr. Salehi testified that Petitioner denied any symptoms prior to his work-related injuries, but that it was clear Petitioner did have a prior history of symptoms in his lower back and leg. Because of this discrepancy, Dr. Salehi concluded that Petitioner had sustained temporary exacerbations. (RX2, p. 26) He thought that Petitioner could return to work with restrictions of no lifting more than 20 to 35 pounds. (RX2 p. 27) He recommended additional diagnostic studies and suggested that Petitioner may require therapy or even surgery. (RX2, p. 28)

Pursuant to Section 12 of the Act, Advocate South Suburban Hospital secured an evaluation by Dr. Edward Goldberg of Petitioner on August 17, 2012. Following his

examination of Petitioner and review of Petitioner's medical records and diagnostic studies, Dr. Goldberg concluded that Petitioner had degenerative disc disease at L4-5 and L5-S1. (SSH3, p. 11) Dr. Goldberg agreed that Petitioner was a surgical candidate. He also agreed with the need for work restrictions. Dr. Goldberg found no differences between the pre- and post-March 7, 2012 lumbar MRIs. In his addendum report, dated March 2, 2013, Dr. Goldberg concluded that Petitioner's need for surgery was not due to the injury he sustained while working for Advocate South Suburban Hospital on March 7, 2012. (SSH3, p. 12) His conclusion was based upon the discrepancy between what Petitioner told him on August 17, 2012 and the medical records. Petitioner reported to Dr. Goldberg on August 17, 2012 his original radicular pain was in the right leg, but that it is different now. He occasionally gets left leg radicular symptoms. Yet, Dr. Goldberg, after perusing the medical records, found that Petitioner had experienced left leg radicular pain prior to March 7, 2012 and had received prior treatment for same. (SSH3, pp. 12-13)

Dr. Michael Zindrick saw Petitioner on April 8, 2013. Dr. Zindrick secured a history from Petitioner and performed a physical examination. (PX8, pp. 6-8) He reviewed lumbar spine MRI films from studies performed in August 2010 and March 2012. (PX8, p. 10) His diagnosis was that Petitioner had a progression of the disk abnormality at L4-5 and L5-S1 level on MRI, and also a significant change in his symptoms secondary to the March 7, 2012 incident, which Dr. Zindrick stated was the cause of the Petitioner's symptoms and disability. (PX8, p. 11) Dr. Zindrick's opined that Petitioner had significantly increasing back pain, of a disabling nature, after his accident in March 2012. (PX8, p. 11) He has recommended an L4-5 laminectomy and fusion with cages and internal fixation, diskectomy and nerve decompression. (PX8, pp. 16-17) Dr. Zindrick stated that prior to March 2012, Petitioner was not an individual

who should have been working with unrestricted lifting tasks because he was at risk of re-injury. (PX8, p. 18)

Petitioner testified that he would like to undergo the surgery that Dr. Michael Zindrick has proposed. (Tr. 52-53)

CONCLUSIONS OF LAW:

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

Claimant has the burden of proving, by a preponderance of the evidence, the elements of his claim. It is the function of the Arbitrator to judge the credibility of the witness and resolve conflicts in medical evidence. O'Dette v. Indus. Comm'n, 79 Ill.2d 249 (1980).

It is well established that employers take their employees as they find them.

An accidental injury need not be the sole causative factor, nor even the primary causative factor, as long as it was a causative factor in the resulting condition of ill-being. Sisbro. Inc. v. Indus. Comm'n, 207 Ill.2d 193, 205 (2003).

The Arbitrator finds that Petitioner was injured in an accident on March 7, 2012 while in the course of his employment by Respondent Advocate South Suburban Hospital ("Advocate"). The parties, Petitioner and Respondent HCR Manor Care ("HCR"), stipulate that Petitioner was injured while working for Respondent on July 29, 2010 and October 29, 2010. (AX1)

The Arbitrator finds that Petitioner did suffer an accident on March 7, 2012 while working for Respondent Advocate. The Arbitrator finds that Petitioner suffered an accident when he experienced discomfort while lifting garbage bags and tossing them into a gondola over 5 feet in the air. Immediately after the pain began, Petitioner testified his pain worsened to the point that he lost consciousness. He was taken by co-workers to the Emergency Department at

Respondent's hospital, where he was admitted as an inpatient. He received an epidural steroid injection and remained inpatient for several days.

The Arbitrator recognizes that the initial medical histories that were taken after Petitioner's March 7, 2012 injury make no mention of any garbage bag lifting/tossing activity, or any other work-related activity. However, Petitioner testified that after he lifted and tossed the garbage bags, his back pain worsened until it became severe and traveled down his leg, the pain hit him so hard that he blacked out and he received help to the emergency room from his co-workers. Respondent Advocate presented no witness to rebut this testimony.

The initial medical histories do state that at the time of the injury, Petitioner was at work, his left leg became weak, numb and tingly and he dropped to the floor. Such histories also indicate that Petitioner's left leg weakness was a new symptom.

Doctors Goldberg, Salehi, Yapor and Zindrick indicated that Petitioner's condition worsened significantly after March 2012 injury. Before the March 2012 accident, Petitioner was able to perform his job duties. His condition has not responded to conservative treatment. He has been unable to work since March 7, 2012.

Dr. Salehi's opinion that Petitioner's March 2012 aggravation of his back condition was temporary is contradicted by evidence in this case. After reviewing the transcript of Dr. Salehi's deposition, the Arbitrator found this neurosurgeon to lack credibility.

Dr. Goldberg acknowledged that although Petitioner had prior symptoms of back problems and had suffered exacerbations in the past, those were temporary. Dr. Goldberg acknowledged that Petitioner's current condition will not improve without surgery. Dr. Goldberg acknowledged that Petitioner requires prescription pain medication and can perform sedentary work.

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

Based on Petitioner's testimony, the medical records and the opinions of Dr. Zindrick and Dr. Yapor, the Arbitrator finds that Petitioner's current condition of ill-being is causally related to the accidents of July 29, 2010 and October 29, 2010.

Petitioner bears the burden of establishing that his current condition of ill-being is causally related to the accident on March 7, 2012, by a preponderance of the credible evidence. Hannibal v. Indus. Comm'n, 38 Ill.2d 473 (1967).

Petitioner worked at Respondent HCR before his injury on July 29, 2010. He performed all duties he was directed to perform. After his July 29, 2010 injury, he missed no time from work and his symptoms abated with conservative treatment. He continued to work for HCR until his October 29, 2010 injury. After this injury, he underwent conservative treatment. His symptoms improved and, after missing 5-1/7 weeks from work, he returned to full-duty work for Respondent HCR.

Petitioner left the employ of Respondent HCR, but continued to treat conservatively for his ongoing back symptoms. As of October 2011, he had not reached maximum medical improvement, according to Respondent's Section 12 Examination by Dr. Yapor. Petitioner received an epidural steroid injection in December 2011 and took prescription pain medication to address his symptoms up until at least February 7, 2012.

Petitioner began working for Respondent Advocate in February 2011. After performing his duties for Respondent Advocate for over a year, he was injured while working on March 3, 2012. Petitioner described the pain he experienced after this injury as markedly different from previous back pain he had experienced. He testified his pain after the March 7, 2012 injury

began to radiate into his left leg, which he described as "new." (PX1, pg. 5) Petitioner has not been able to return to work in any capacity since the March 7, 2012 injury he described.

Unlike previous exacerbations of Petitioner's back symptoms, he now experienced radiating pain down his legs to his feet. These symptoms persisted to the date of hearing, and have not responded to conservative treatment.

Additionally, the records indicate that left le weakness and giving way was a new symptom.

Petitioner's physician, Dr. Zindrick, testified that Petitioner's condition worsened significantly after the third incident in 2012 in that Petitioner did not respond to conservative treatment and has been unable to return to work or alleviate his symptoms. Dr. Zindrick, Dr. Goldberg and Dr. Yapor all agree Petitioner now requires back surgery. Dr. Salehi opined that Petitioner may require back surgery.

The Arbitrator finds that because Petitioner sustained an injury to his back or aggravated the condition of his back on March 7, 2012 while working for Respondent Advocate, he is now compelled to undergo surgery.

The Arbitrator bases his findings on the testimony of Petitioner, the medical records and the evidence depositions. Moreover, the Arbitrator finds that National Freight Industries v. Illinois Workers' Compensation Commission, 993 N.E.2d, 373 Ill. Dec. 167 (5th Dist. 2013), is analogous to the facts and circumstances of this case. In National Freight, Andrew Smith, claimant, suffered a lifting injury while working for Fischer Lumber. His injury required surgery. Smith left the employ of Fischer Lumber and began working for National Freight Industries. He had not reached maximum medical improvement. On the eve of his scheduled surgery, claimant was involved in a motor vehicle accident while working for National Freight

Industries. The court found that the motor vehicle accident changed the nature of claimant's injury and required that he undergo a more extensive procedure. The court found that there was evidence that the motor vehicle accident caused a change in the pathology of claimant's condition.

In this case, Dr. Zindrick opined that Petitioner had abnormalities in the lumbar spine at L4-5 and L5/S1, which predated his third injury in March 2012. (PX8, pp. 35-36). However, he noted that as a result of the March 2012 accident, Petitioner's symptoms have become significantly more symptomatic and failed to respond to conservative treatment. Dr. Zindrick suggested that Petitioner had a progression of the disk abnormality at the L4-5 and L5/S1 level secondary to the March 7, 2012 incident. (Id. pp. 12-13) Dr. Zindrick noted that after the 2012 incident, Petitioner's symptoms significantly increased to the point of being disabling in nature.

The facts and circumstances of this case are distinguishable from Vogel v. Indus. Comm'n, 354 Ill.App.3d 780 (2005). In Vogel, the court found that a series of three motor vehicle accidents after claimant's cervical fusion surgery did not break the causal connection between claimant's work-related injury and his condition of ill-being.

In the instant case, Petitioner's symptoms and level of disability changed markedly after the March 7, 2012 incident. He now has left leg weakness. Petitioner has been unable to work since the March 7, 2012 accident whereas after the July 29, 2010 and October 29, 2010 exacerbations, he was able to return to work.

The Arbitrator concludes that Petitioner's current condition of ill-being is causally related to the March 7, 2012 accident he sustained while working for Respondent Advocate.

The Arbitrator makes no determination regarding the permanent partial disability Petitioner has suffered as a result of the accidents that occurred in 2010 or 2012 as that issue is not before the Arbitrator at this time.

J. Were the medical services that were provided to Petitioner reasonable and necessary?

The Arbitrator incorporates here his findings of fact and conclusions of law with respect to the issues of accident and causation.

The Arbitrator has reviewed the treatment and corresponding medical bills following Petitioner's July 29, 2010 and October 29, 2010 accidental injuries and finds such to be reasonable, necessary and related. The Arbitrator orders Respondent HCR to pay such bills pursuant to Section 8(a) and subject to Section 8.2. Respondent HCR is entitled to a credit in the amount of $15,654.33 for previously paid medical bills.

The Arbitrator has reviewed the treatment and corresponding medical bills following Petitioner's March 7, 2012 accidental injury and finds such to be reasonable, necessary and related. The Arbitrator orders Respondent Advocate to pay the following bills pursuant to Section 8(a) and subject to Section 8.2 of the Act: Advocate Medical Group (PX5), $1,513; Advocate South Suburban Hospital (PX4), $15,427.00; Hinsdale Orthopaedics (PX6), $511.00; Injured Workers Pharmacy (PX9), $5,037.96. Respondent Advocate is entitled to a credit for any and all medical bills they have previously paid.

K. Is Petitioner entitled to any prospective medical care?

Dr. Zindrick, Dr. Goldberg and Dr. Yapor have opined that Petitioner requires surgery to his low back. Dr. Salehi opined that Petitioner may require low back surgery.

Michael Zindrick, M.D., has recommended that Petitioner undergo an L4-5 laminectomy and fusion with cages and internal fixation, diskectomy and nerve decompression, as well as a back brace, physical therapy and work conditioning.

Based on the foregoing, including his findings on the issues of accident and causation, the Arbitrator orders Respondent Advocate to pay the treatment that Dr. Zindrick has recommended, pursuant to Section 8(a) and subject to Section 8.2 of the Act.

L. **What temporary benefits are in dispute?**

Following the October 29, 2010 accident, Respondent HCR paid temporary total disability benefits from November 3, 2010 through December 8, 2010. Respondent HCR is entitled to a credit in the amount of $5,274.42 for payment of that period of temporary total disability as well as for payment of a period of temporary total disability that followed the March 7, 2012 accident.

Following Petitioner's March 7, 2012 accident, no doctor has released Petitioner to return to full-duty work. There is no evidence that Respondent Advocate has offered Petitioner a light-duty position.

Based on the foregoing, including his findings on the issues of accident and causation, the Arbitrator orders Respondent Advocate to pay temporary total disability benefits from March 8, 2012 through August 15, 2013. Respondent is entitled to a credit in the amount of $15,737.91 for TTD benefits previously paid.

M. Should penalties or fees be imposed upon the respondent?

The imposition of Section 19(k) penalties and Section 16 attorneys' fees can only be assessed when a delay in benefit payment is deliberate or the result of bad faith or 'improper purpose.' An employer's reasonable and good faith challenge to liability does not warrant the imposition of penalties. Section 19(l) penalties can only be awarded if the employer cannot show an adequate justification for the delay. The standard is reasonableness. USF Holland v. Indus. Comm'n, 357 Ill.App.3d 798 (2005).

Advocate South Suburban Hospital relied upon the opinions of orthopedic surgeon Edward Goldberg, M.D., to assert that Petitioner's condition of ill-being is not causally related to his March 7, 2012 accident.

Moreover, approximately 4 weeks prior to the March 7, 2012 accident, Petitioner sought treatment for his low back pain with Dr. Dixit. At that time, Petitioner asked Dr. Dixit for a referral to a pain management physician so that he could receive epidural steroid injections.

Furthermore, Petitioner's initial medical histories taken after his March 7, 2012 injury make no mention of any garbage bag lifting/tossing activity, or any other work-related activity.

Petitioner and Respondent Advocate agreed that Respondent Advocate would pay Petitioner TTD benefits at one-half the TTD rate in order to avoid exposure to a claim by Petitioner pursuant to Sections 19(l), 19(k) and 16 of the Act, while the payments were made. The parties' agreement did not apply to the period of time in which TTD benefits were owed and not paid at ½ rate or full rate by Respondent Advocate.

Arbitrator's Exhibit #1 indicates that Respondent Advocate paid $15,737.91 in TTD benefits for the period 3/8/12 - 3/7/13, and that Respondent HCR paid $2,422.10 in TTD benefits for the period 5/14/12 – 7/16/12.

Based on the foregoing, including his findings on the issues of accident and causation, the Arbitrator finds that Respondent Advocate's denial was reasonable and represented a good-faith challenge to liability.

The Arbitrator further finds that Respondent HCR's denial was reasonable and represented a good-faith challenge to liability. Respondent HCR relied on the opinions of Dr. Salehi.

Consequently, the Arbitrator denies Petitioner's petitions for penalties and attorneys' fees.

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

Martin Lenz,
Petitioner,

vs.

NO: 08 WC 02825

Waste Management of Illinois, Inc.,
Respondent.

15IWCC0063

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 and benefit rate 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 31, 2013, is hereby affirmed and adopted.

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: JAN 2 3 2015

o-01/14/15
drd/wj
68

Daniel R. Donohoo

Charles J. DeVriendt

Ruth W. White

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

LENZ, MARTIN
Employee/Petitioner

Case# **08WC002825**

WASTE MANAGEMENT OF ILLINOIS INC
Employer/Respondent

15IWCC0063

On 12/31/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.09% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4069 LAAW OFFICE OF JONATHAN SCHLACK
200 N LASALLE ST
SUITE 770
CHICAGO, IL 60601

1109 GAROFALO SCHREIBER HART ETAL
STEVE SCARLATI JR
55 W WACKER DR 10TH FL
CHICAGO, IL 60601

STATE OF ILLINOIS)
)SS.
COUNTY OF Illinois)

☐ 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

Martin Lenz
Employee/Petitioner

v.

Waste Management of Illinois, Inc.
Employer/Respondent

Case # 08 WC 02825

Consolidated cases: D/N/A

15IWCC0063

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Mason**, Arbitrator of the Commission, in the city of **Chicago**, on **November 26, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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. X☐ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance X TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On **December 13, 2007**, Respondent *was* operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship *did* exist between Petitioner and Respondent. Arb Exh 1.

On this date, Petitioner *did not* sustain an accident that arose out of and in the course of employment. Based on this finding, the Arbitrator views the remaining disputed issues as moot. The Arbitrator makes no findings as to those issues.

Petitioner provided Respondent with timely notice of his claimed accident. Arb Exh 1.

In the year preceding the claimed injury, Petitioner earned **$39,520.00**; the average weekly wage was **$760.00**. Arb Exh 1.

On the date of the claimed accident, Petitioner was **28** years of age, ***single*** with **2** dependent children. Arb Exh 1.

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

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

ORDER

For the reasons set forth in the attached, the Arbitrator finds that Petitioner lacked credibility and failed to prove he sustained an accident on December 13, 2007 arising out of and in the course of his employment by Respondent. The Arbitrator views the remaining disputed issues as moot and makes no findings as to those issues.

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

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

Molly C Mason
Signature of Arbitrator

12/31/13
Date

DEC 31 2013

Martin Lenz v. Waste Management
08 WC 2825

15IWCC0063

Arbitrator's Findings of Fact

Petitioner claims he injured his neck while working for Respondent on December 13, 2007. As of that date, Petitioner had worked as a "low level mechanic" for Respondent for about 1 ½ to 2 years. T. 14-15. He performed "PM," or preventive maintenance, on garbage trucks. He typically worked from 4:00 PM to midnight. T. 15-16, 19.

Petitioner testified that, at about 11:30 PM on December 13, 2007, he was leaning over an engine, using both hands to forcefully pull induction tubing toward him. The tubing was "stubborn" and it was difficult to get it to line up correctly. As Petitioner pulled, he felt his neck pop. Afterward, he was no longer able to turn his head but managed to finish his shift. Before he left work, he told Mike Moorehead and Theron Hunter, a supervisor, about his injury. T. 20-21. After he got home, he was still having trouble moving his head. He took some aspirin. He found it difficult to sleep. He was scheduled to work the following day, a Friday. When he woke up, his neck felt a little stiffer but he went to work. He arrived at work a little early, at 1:00 or 2:00 PM, so that he could report his injury to Mark, the day shift supervisor. He told Mark he felt his neck pop while pulling on an induction line the previous night. Mark asked if he would be able to work and he said he would try. Mark then said, "try to get through your day and the weekend will come around – we'll see how you feel." T. 23.

Petitioner could not recall whether he managed to finish his shift on Friday, December 14th. He was off work the next two days. His pain worsened as the weekend went by. T. 24.

Petitioner did not recall going to work on Monday, December 17th. He sought treatment that day at the Chicago Neck & Back Institute. He had previously seen advertisements for this clinic. The clinic was close to his mother's house, where he was then living. T. 25-26.

Petitioner saw Dr. Cicero, a chiropractor, at the Chicago Neck & Back Institute on December 17, 2007. The doctor's handwritten note reflects that Petitioner complained of pain in his neck and upper back as well as difficulty moving his head. The note also reflects that Petitioner attributed his pain to a work injury that occurred on December 13, 2007. The doctor indicated that Petitioner was "leaning over an engine, jerking on a tube pipe when he felt a pop in his neck" and pain that "eventually went away in 30 minutes, which was the end of his work shift." The doctor noted that Petitioner "woke up with more pain" the following day but went to work earlier than usual. [The following sentence is very difficult to read.] The doctor then indicated that Petitioner "did not fill out a report because work did not bring it up and [Petitioner] thought the pain would go away."

Dr. Cicero indicated that, prior to the work accident, Petitioner had experienced only one day of neck pain five years earlier, with that pain fully resolving. He noted that Petitioner reported being "in good health" prior to December 13, 2007.

Dr. Cicero commented that Petitioner's examination "unequivocally demonstrates inflam[mation] of the spinal nerve along w/ reactionary spasms and disc inj." He administered an ice massage. He fit Petitioner with a hard neck collar and instructed Petitioner to wear this collar at all times other than when sleeping. He prescribed anti-inflammatories and released Petitioner to ground level office work with use of the collar, no lifting over 5 pounds and no over the shoulder work. PX 1, p. 35. The following phrase appears at the bottom of the doctor's work status note: "injured neck on 12/13/07 while at work." PX 1, p. 35. Dr. Cicero instructed Petitioner to return to him in two days.

Petitioner testified he reported to work on Tuesday, December 18, 2007 and again reported his injury to Mark. At Respondent's direction, he left work and went to a clinic. He recognized "Elmhurst Memorial Occupational Health Services" as the name of this clinic. T. 27-28.

The records from Elmhurst Memorial Occupational Health Services include a handwritten nurse's note dated December 18, 2007. This note reflects that Petitioner reported injuring his upper back and neck "about 5 days ago at work [while] pulling on some engine pipes." The note also reflects that Petitioner complained of pain radiating down his right arm. PX 2, p. 8.

The records also include a lengthy handwritten note authored by Bonnie McManus, M.D. This note is very difficult to read. The first line appears to state that Petitioner experienced an abrupt onset of pain five days earlier while pulling engine parts. Subsequent lines reference Petitioner's subsequent visit to a chiropractor. On examination, Dr. McManus noted "midline tenderness at T1-2," mild trapezius tenderness and increased neck pain with turning of the head. Dr. McManus ordered thoracic spine X-rays, which showed only mild levoscoliosis. Dr. McManus prescribed Skelaxin and physical therapy. She released Petitioner to light duty with frequent lifting up to 5 pounds, occasional lifting of 5-10 pounds, no lifting over 10 pounds, occasional driving and standing and no pushing/pulling, climbing, kneeling, bending, twisting, reaching above shoulder level or repetitive movement. She scheduled Petitioner to start therapy on December 20th and to return to the clinic on December 21st. PX 2, p. 15. She identified Respondent's contact person as John Geger or Gerger.

Petitioner testified he attended a safety meeting at work on either December 18 or 19, 2007. The meeting took place in the break room. T. 29. Todd Pirkins, Mike Moorehead and several other members of Petitioner's shop attended this meeting. T. 30. Petitioner testified that Pirkins led off by asking him to describe how he had been injured so that Respondent could prevent a similar accident from occurring in the future. T. 30, 35-36. Petitioner testified he was starting to tell how he had been injured when Mike Moorehead stood up and interrupted him, calling him a liar. T. 30, 40. Petitioner then asked Moorehead, "Why are you doing this? Why are you calling me a liar?" T. 30.

Petitioner testified that, prior to this meeting, he had regularly attended safety meetings at Respondent. These meetings took place about every two months. Petitioner testified that other workers had sustained injuries prior to his own injury but that these injuries were not brought up at the meetings he attended. T. 34.

Petitioner testified that Respondent paid him on an hourly basis. He did not receive year-end bonuses. Before his accident took place, he and his co-workers were hoping to receive safety bonuses at the end of the year. Such bonuses were paid when Respondent operated for a certain period with no injuries taking place. T. 37. According to Petitioner, each worker would receive $200 extra "if no one was hurt." T. 37-38.

Petitioner testified he was "shocked" when Moorehead accused him of lying. After Moorehead made the accusation, Petitioner looked at Pirkins, who then said, "oh, I see what's going on, I know what's going on." At that point, the safety meeting ended. Petitioner testified Respondent fired him, via letter, the day after the meeting. T. 40. RX 2.

Petitioner returned to Dr. Cicero on December 21, 2007, following his termination. Petitioner reported some improvement but indicated he was still having trouble moving his head. He also complained of a new symptom, i.e., left arm weakness. Petitioner also reported having been terminated following a visit to a company clinic. Dr. Cicero noted the following concerning the termination:

> "He was sent to the company clinic on 12/18/07 which was Elmhurst Memorial Occup Health Serv and was DX'd w/ thoracic strain. He was also put on LD; however, on the following day, was terminated. He advised me that they terminated him because he falsified information regarding his work injury. He admits that he did not falsify any information and that he was wrongfully terminated."

Dr. Cicero described Petitioner's examination findings as unchanged other than "new onset" reduced strength in the left C5-C6 area. Dr. Cicero prescribed a cervical spine MRI. He noted Petitioner was "having problems w/ his WC carrier" and might have to go through his group carrier to get the MRI done. He instructed Petitioner to continue wearing the hard collar. He also recommended Advil. PX 1, p. 34.

Petitioner next saw Dr. Cicero on December 24, 2007. On that date, Petitioner complained of increased pain in his neck and upper back. He also complained of persistent left arm weakness. He indicated he had not yet scheduled the MRI. Dr. Cicero again recommended the MRI. He also continued the previous light duty restrictions. He instructed Petitioner to continue wearing the neck collar. PX 1, p. 34.

The cervical spine MRI, performed on January 2, 2008, revealed a "relatively large" right central disc herniation at C5-C6 and right foramen stenosis at the same level. PX 1, p. 41. PX 3.

Petitioner also saw Dr. Cicero on January 2, 2008. Petitioner complained of increased pain secondary to lying still during the MRI. Dr. Cicero administered various forms of therapy and continued the previous restrictions. PX 1, p. 37.

Petitioner returned to Dr. Cicero on January 4, 2008 and reported some improvement. He indicated he had been unable to work since his termination. Dr. Cicero reviewed the MRI films. He noted a "smaller herniation at C6-C7" in addition to the C5-C6 herniation noted by the radiologist. He recommended that Petitioner continue chiropractic care but also see Dr. Wilson, a neurologist. He continued the previous restrictions. PX 1, p. 37.

Petitioner continued undergoing treatment with Dr. Cicero following January 4, 2008. N January 14, 2008, Dr. Cicero revised the previous restrictions. He released Petitioner to work with no lifting over 5 pounds with the left arm, no lifting over 15 pounds with the right arm and limited repetitive use of the left arm. PX 1, p. 46.

On January 16, 2008, Petitioner saw Dr. Wilson and complained of neck pain radiating into his left shoulder and arm. He also complained of tingling between his shoulder blades. The doctor noted that Petitioner became symptomatic after pulling a heavy load at work on December 14th and feeling something pop in his neck. The doctor also noted that Petitioner denied any previous neck or back injuries.

On examination, Dr. Wilson noted pain with passive range of motion of the neck, particularly to the left, and no focal sensory loss. Given the severity of Petitioner's pain, he recommended a Prednisone taper followed by Lodine. He indicated Petitioner should undergo a repeat MRI if his shoulder blade tingling worsened. He also recommended continued therapy. PX 1, p. 44.

Petitioner continued seeing Dr. Cicero after his consultation with Dr. Wilson. On January 23, 2008, Dr. Cicero noted that Petitioner was on his third day of the Prednisone taper but was still experiencing neck pain. PX 1, p. 49. On February 15, 2008, Dr. Cicero imposed new restrictions of no lifting over 20 pounds with the right arm, no lifting over 10 pounds with the left arm, limited repetitive use of the left arm and minimal overhead movement. PX 1, p. 57. Three days later, Dr. Cicero recommended that Petitioner see Dr. Wilson again. PX 1, p. 59. On February 29, 2008, Dr. Cicero noted increased neck and upper back symptoms of two days' duration. He also noted a new complaint of right arm pain. He revised the previous restrictions, limiting Petitioner to lifting no more than 10 pounds with his right arm and no more than 5 pounds with his left arm. He recommended EMG/NCV testing. PX 1, pp. 62-66. On March 6, 2008, Dr. Dixon performed the recommended testing. He described the nerve conduction studies as normal but noted that the EMG showed a "right acute mild C6 radiculopathy." PX 1, pp. 67-70. PX 4. On March 10, 2008, Dr. Cicero noted the abnormal EMG

results and again recommended that Petitioner follow up with Dr. Wilson. He also referred Petitioner to Dr. Slack for a surgical opinion. PX 1, pp. 71-72.

Petitioner returned to Dr. Wilson on March 12, 2008. The doctor noted that Petitioner complained of neck pain and numbness in his left index finger of two days' duration. He indicated that Petitioner began to experience this numbness while using a computer. On examination, the doctor noted some mild paraspinal tightness in the neck, good strength and a decreased biceps jerk on the left. He addressed Petitioner's symptoms as follows:

> "The patient has a cervical radiculopathy. Clinically, he clearly has symptoms on the left. However, the MRI scan and EMG both are consistent with symptoms on the right. I am not certain how to reconcile these observations."

He recommended a repeat steroid taper, a cervical epidural steroid injection and continued therapy. PX 1, p. 75.

Petitioner returned to Dr. Cicero on March 19, 2008, with the doctor noting Dr. Wilson's findings. Dr. Cicero indicated that, despite Dr. Wilson's comments, it was "not unusual to have a herniation to the right at [C5-C6] causing left-sided C5-C6 symptoms." He scheduled Petitioner to undergo a cervical epidural steroid injection and again recommended that Petitioner see Dr. Slack. PX 1, p. 77.

On May 15, 2008, Petitioner saw Dr. Slack, a spine surgeon affiliated with Midwest Orthopaedics. Dr. Slack's note sets forth a consistent history of the work accident. Dr. Slack noted that Petitioner reported improvement of his neck pain secondary to therapy but complained of numbness in his fingertips and hands as well as occasional sharp pain between his shoulder blades.

On examination, Dr. Slack described Petitioner's neck range of motion as good and painless. He described upper extremity strength, reflexes and sensation as intact. He noted some tingling in the fingertips. He reviewed the cervical spine MRI report and film, along with the EMG/NCV report and Dr. Wilson's notes.

Dr. Slack diagnosed a "persistent cervical derangement associated with a C5-C6 disc herniation." He addressed causation as follows: "it appears that the patient's symptoms are causally related to his injury on the job of December 2007, as he denied any problems prior to that time." He prescribed Lyrica and a Lidoderm patch. He noted that Petitioner could undergo a cervical epidural injection if this medication did not help. He found Petitioner to be temporarily totally disabled. PX 1, pp. 86-87. PX 5, pp. 2-3.

On June 9, 2008, Petitioner underwent a cervical epidural steroid injection. Dr. Saavedra performed this injection. Dr. Saavedra's handwritten report concerning the injection

reflects that Petitioner's symptoms began after he "pulled a pipe from the engine of the garbage truck on Thursday, Dec 3 or 4, '07." PX 6. Two days after the injection, Dr. Cicero noted that Petitioner reported a significant reduction in his symptoms. On June 16, 2008, however, Dr. Cicero noted that Petitioner was again experiencing upper back and scapular pain, along with right arm pain. Dr. Cicero noted that it was "unusual for symptoms in the extremities to switch from one side to the other, especially after an epidural steroid injection." He recommended that Petitioner undergo a second injection. PX 1, p. 90. He wrote out a work status report indicating Petitioner should be off work from June 9, 2008 through June 23, 2008. PX 1, p. 92. Petitioner underwent a second injection on June 16, 2008. T. 46. On June 23, 2008, Dr. Cicero instructed Petitioner to remain off work through July 7, 2008. PX 1, pp. 95, 98. On July 9, 2008, Dr. Cicero instructed Petitioner to remain off work through July 14, 2008. PX 1, p. 101.

On August 11, 2008, following additional therapy, Dr. Cicero noted that Petitioner denied arm symptoms, complained of only occasional neck pain and reported feeling stronger. Dr. Cicero recommended that Petitioner undergo a functional capacity evaluation and begin looking for employment. He increased Petitioner's lifting capacity to 25 pounds. PX 1, pp. 111-112.

Petitioner continued undergoing therapy thereafter. On September 15, 2008, Dr. Cicero noted improvement. The doctor performed a "physical performance examination," testing Petitioner's strength and endurance. He released Petitioner to work with limited overhead activity, maximum lifting of 20 pounds and repetitive lifting limited to 10 pounds. He indicated he planned to begin a new form of care, i.e., "non-surgical decompression," at the next visit. He encouraged Petitioner to seek employment. PX 1, p. 127.

Petitioner last saw Dr. Cicero on November 17, 2008. In his note of that date, Dr. Cicero indicated that Petitioner denied any neck, upper back or arm symptoms and reported feeling "like he did prior to his work injury." The doctor conducted another physical performance examination, along with a functional capacity evaluation. He noted that Petitioner was able to lift 120 pounds from floor to waist, lift 92 pounds from waist to chest and lift 30 pounds from chest to overhead.

Dr. Cicero described Petitioner as having gained significant strength in his upper body and legs. He found it unnecessary to repeat the MRI. He indicated that, although Petitioner had "greatly improved," disc herniations "never fully and completely resolve." He recommended that Petitioner start a home traction maintenance program "to keep the discs from getting larger." He released Petitioner to full truck mechanic duty but cautioned Petitioner that he "does not have a normal neck despite his improvement." He found permanency and recommended that Petitioner use good body mechanics and avoid sudden movements. He also recommended that Petitioner return to him in one month. PX 1, pp. 140-142. [There is no evidence indicating Petitioner returned to Dr. Cicero after November 17, 2008.]

Petitioner testified he was off work for a year after his December 13, 2007 injury. T. 52. The treatment that Dr. Cicero provided helped him (T. 53) but he is still only "80% of what he was" before his December 13, 2007 accident. His lingering neck complaints affect his ability to work. During the last three years, he has worked as a mechanic for Ryder. T. 47-48, 51. If he performs work above shoulder level, he begins feeling neck pain. T. 48-49. He is able to work 40 hours per week but experiences symptoms at work once each workday. When he is at home, he notices neck pain and "locking" while watching television, lying on his left side or playing with his four young children. He avoids carrying his children on his shoulders. T. 50.

Under cross-examination, Petitioner testified that the care he underwent with Dr. Cicero consisted of traction, massages, stretching, electro-stimulation and various exercises. T. 55-57. He felt "pretty good" when he last saw Dr. Cicero but did not feel the same as before the accident. T. 64. The first job he held after resuming work was with CDN. At CDN, he was a non-union mechanic. His current job with Ryder is a union position. T. 60. He reported his injury to Mike Moorehead on the night the injury occurred. He did not tell Moorehead that his neck was hurting when he arrived at work earlier that same night. T. 65. Petitioner initially testified he and other employees received safety bonuses while working for Respondent. T. 66-67. He subsequently admitted he did not recall whether he received a safety bonus before the accident. T. 69. His understanding was that each employee would receive $200 if the shop went a certain period without anyone having an injury. T. 70. He gained this understanding from Mark, Mike Moorehead and Theron Hunter. T. 70-71. It is possible Respondent held safety meetings every two weeks rather than every three or four months. T. 71. It is possible that the meeting held on December 18, 2007 was a regularly scheduled meeting. T. 72. Mike Moorehead accused him of lying during the December 18, 2007 meeting. After this meeting, he met with Todd Pirkins in Pirkins' office. T. 73. Pirkins had questioned him about the accident before the meeting. T. 74. He did not tell Pirkins that his neck was sore when he arrived at work on December 13, 2007. Nor did he tell Pirkins that he claimed a neck injury because he was having an attendance problem. T. 74. He did not tell Pirkins that he did not view bringing a false claim as a big deal since a friend of his had done this while working for a different company. T. 75. He did tell Pirkins he was considering resigning. After he mentioned this to Pirkins, Pirkins said, "hold on, let me see what upper management wants to do." T. 75. After he met with Pirkins, Respondent sent him a letter terminating his employment because he allegedly filed false documents claiming a work injury. T. 76. He filed a grievance with his union after being terminated but the union "didn't want any part of it." T. 76. The union did not hold a hearing in connection with his grievance. He followed up with the union and was told that the best thing the union could do for him was to help him find another job. T. 77. He was very upset that his union did not help him. He continues to pay union dues, since Ryder is a union shop, but he is not happy with his union. T. 79. He believes he worked all day on Friday, December 14, 2007 but his neck got worse that day. He did not see a doctor on Saturday or Sunday because he thought he would improve on his own and "wanted to get better for Monday." T. 81. He called work on Monday and indicated he was going to see a doctor that day. T. 82.

On redirect, Petitioner testified he did not recall telling Dr. Cicero his neck was not normal when he last saw the doctor in November of 2008. T. 83. At that last visit, Dr. Cicero recommended a home traction unit and told him to avoid certain activities. T. 83. He did not need to be told this because he was already exercising caution due to persistent neck pain. T. 84.

Todd Pirkins testified on behalf of Respondent. Pirkins testified he worked as a district fleet manager for Respondent as of December 13, 2007. He still works in this capacity. T. 87-88. As of December 13, 2007, he oversaw two Respondent shops. One shop was in Wheeling and the other was in Franklin Park. His role was to make sure that everything ran smoothly at these shops. T. 88. Per Respondent protocol, safety meetings were held every two weeks. If an employee sustained an injury, that injury would be discussed at a meeting. T. 91.

Pirkins testified he first learned of Petitioner's claimed December 13, 2007 accident on the morning of the Monday that followed the accident. He learned of the accident from Petitioner. Petitioner called him and said he was going to a clinic because he felt as if something had happened in his neck the previous week. Petitioner did not come to work that day. T. 92-93. Petitioner came to work the following morning and met with Freddy Largos, a supervisor. Largos called Pirkins, who was at the Wheeling shop, and told Pirkins that Petitioner wanted to go to a clinic. Pirkins testified he told Largos to "get the ball rolling" by completing an accident report and sending Petitioner to a clinic. Pirkins then drove to the Franklin Park shop. After Petitioner returned from the clinic, Petitioner told him he believed he had been injured while "putting an induction pipe together" at 11:30 PM. T. 95-96. A safety meeting was already scheduled for 3:30 PM that afternoon. T. 96-97. At that meeting, he asked Petitioner to describe how he had been injured. As Petitioner began to talk, Mike Moorehead interrupted and said to Petitioner, "Marty, that's not what happened – that's not true at all." T. 97-98. Respondent had a bonus program as of December 13, 2007 but the bonuses were based on individual attendance, job performance and safety. If Petitioner had indeed suffered an injury on December 13, 2007, that would not have affected other workers' entitlement to bonuses. T. 98. Mike Moorehead no longer works for Respondent. T. 99. Moorehead's accusation took him [Pirkins] by surprise. He called Petitioner into his office after the meeting. He cannot recall what Petitioner said "word for word" but the gist was that Petitioner admitted his neck was really bothering him before he arrived at work. Petitioner said he did not want to say anything about his neck pain because he had already received an attendance-related warning letter and did not want to lose his job. Pirkins replied, "Marty, do you realize what you did here is you committed perjury? You basically lied on a form and admitted to it." T. 101. Pirkins also said, "you're trying to get workman's comp and you didn't do it at work." At that point, Petitioner "got really quiet" and then asked if he was going to get in trouble. Pirkins replied, "I don't know, Marty. This is out of my league. I need to contact our HR department and talk to them and see what the protocol is here." In response, Marty said, "well, I should probably just resign." Pirkins replied, "well, I don't know if resigning is the thing to do, Marty. Let's see if we can work through this and see where this goes." Petitioner said, "no, I'm really nervous. I'm gonna resign."

Pirkins then testified to the following exchange:

> "I go: Marty, if there's one thing – and not that I'm a father figure to the kid or anything because at the time he was younger, but I go: if there's one thing, Marty, you cannot lie. I go: you need to be honest. I go: if you lie, that's where you get yourself in trouble.
>
> And then the thing I can't believe he [Petitioner} told me, and he did, --the last thing he said to me is – well, not the last thing, one of the last things he said to me, he goes: you know, I really don't see what the big deal is. I go: what do you mean? He [Petitioner] goes: my brother's buddy and him were wrestling outside of his apartment, and my . . . brother's friend crashed into the wall and hurt his shoulder. [Petitioner] goes: he [with reference to his brother's friend] works at Standard Equipment and they paid for everything. I said, Marty, that was the dumbest thing you could have told me. I said, why would you tell me that? And he [Petitioner] just looked at me, like . . . I go: you know what, I don't know them well but I know people at Standard, what if I called them and told them something? [Petitioner replied] no, no, don't do that, don't do that. And I said, all right, Marty. I go: you know what, we're done, we're just done. I'll let you know what's gonna happen from here on out. And I don't think [Petitioner] ever came back to work after that. He left and that was the end of it."

T. 103-105.

Pirkins testified it was after this exchange that Respondent terminated Petitioner via a letter sent by certified mail. T. 105.

Pirkins testified his job for Respondent requires him to interact with the union. In his experience, the union is not shy about filing grievances against Respondent. T. 105. In Petitioner's case, he sent a letter to the union explaining what transpired before the termination. T. 106. He never heard back from the union. T. 107. Up until the safety meeting, Petitioner's situation was treated as a workers' compensation claim. It was not until after the meeting and his post-meeting discussion with Petitioner that accident was placed in dispute. T. 107-108.

Under cross-examination, Pirkins testified that, when he and Petitioner spoke by telephone on Monday, December 17th, the day before the safety meeting, Petitioner told him

he had hurt himself at work the previous Thursday. T. 109. He is not sure whether Petitioner first mentioned the specifics of the injury in the accident report or when they met on Tuesday, December 18th. T. 110. During the safety meeting, held on Tuesday afternoon, Moorehead said that Petitioner told him his "neck hurt so bad it was hard for him to get up out of bed and come into work that morning." T. 110-111, 113. It is not possible, however, that, when Moorehead said this, he was referring to a comment Petitioner had made on the morning of Tuesday, December 18th. T. 111. Moorehead was clearly referring to Petitioner having neck pain and difficulty lifting his head off the pillow on Thursday morning. T. 113. He [Pirkins] has been a district fleet manager for Respondent for fifteen years. T. 115. He supervises about twenty people. T. 115. His supervisor is Ross Barker, an area fleet manager. T. 115. When he says that Respondent is very "safety conscious," he means that Respondent is prevention-oriented. T. 117. Respondent conducts a "safety call" every day at 11:30 AM. He [Pirkins] reports any safety-related issues to Rich Grakowski, Respondent's safety manager. T. 116. He [Pirkins] puts pressure on himself in terms of preventing recurrences. T. 117-118. He sometimes feels that the workers he supervises are responsible for their injuries, particularly when the injuries result from negligence. T. 118. When he met with Petitioner after the meeting, he told Petitioner he thought he was committing fraud. He was not angry at Petitioner when he said this. Rather, he was "confused" and "a little bewildered." T. 119. Petitioner did not volunteer that he had done something illegal. It was he [Pirkins] who suggested this. Petitioner's response was to offer to resign. T. 121. At that point, Petitioner seemed child-like. He was "real nervous" but "not afraid." T. 121. He and Petitioner were both sitting down during the discussion. He did not raise his voice when he spoke with Petitioner. T. 122. He expressed disappointment that "someone would lie like that." T. 122. Petitioner admitted that his neck was bothering him Thursday when he got out of bed. T. 122. He [Pirkins] admitted being arrested for driving under the influence thirty years ago, when he was 21. T. 123. He has never been convicted of a felony. T. 123. He does not have any minutes from the safety meeting that led to Petitioner's termination. T. 124. He would have had everyone sign a sheet prior to the meeting but he does not have this sheet. T. 125-126. He is not sure when Moorehead left Respondent's employment. T. 126. After Petitioner left his office, following their discussion, he called Ross Barker, a human resources employee named Jim Carrs and the former safety director, Chris Moore. T. 129. He wrote the letter terminating Petitioner less than 24 hours after the safety meeting. T. 130.

On redirect, Pirkins testified he wrote the termination letter after discussing the situation with upper management. T. 131. When he met with Petitioner, following the safety meeting, Petitioner made no attempt to clarify any misunderstanding that might have existed on Moorehead's part. After he sent the termination letter, no one contacted him to assert that the situation evolved differently. T. 132.

Under re-cross, Pirkins testified that union grievances "start" at his level but are ultimately handled by Respondent's human resources department. He is not a human resources employee. T. 133.

On rebuttal, Petitioner testified he has never been arrested. T. 134. As of his claimed accident, he and his then-girlfriend were expecting a child. He needed his job with Respondent. T. 135. He felt nervous when Pirkins started questioning him because Mike [Moorehead] had just yelled at him and he "knew the guys were worried about the bonus." He was in his boss's office, dealing with "scary stuff." T. 136. He knew it was wrong to falsify a work injury. He would not claim to have been hurt on the job unless he was. T. 137.

Under cross-examination, Petitioner again acknowledged he needed his job with Respondent. Nevertheless, he offered to resign. T. 137-138.

Respondent offered into evidence an undated and unsigned "Supervisor's Incident Report." The first page of this report reflects that Respondent hired Petitioner on October 9, 2006. It also reflects that Petitioner was injured at Respondent's facility in Franklin Park, Illinois, at 11:30 AM on Thursday, December 13, 2007. Fred Lagos is listed as Petitioner's supervisor and Todd Pirkins is listed as the accident investigator. The accident is described as follows: "while pulling on tubing felt a pop in upper back/neck." The last page of the report contains comments indicating Petitioner's judgment was inadequate and Petitioner should have stretched the tubing before pulling it. RX 1.

Respondent also offered into evidence the termination letter that Pirkins sent to Petitioner. The letter is dated December 19, 2007. The letter states in relevant part:

> "You are being terminated and relieved of your duties from Waste Management for falsifying an injury report that you completed on 12/18/07. In this report you stated you hurt yourself at 11:30 pm on 12/13/07 while working on an induction line. During a root cause investigation, it was discovered that you were already injured when you reported to work that day and failed to make mention of this. This is not only unethical it is against company policy and cannot be tolerated."

RX 2. The Arbitrator notes that the record in this case does not include any injury report completed by Petitioner.

[CONT'D]

Martin Lenz v. Waste Management
08 WC 2825

Arbitrator's Credibility Assessment

This case turns on the issue of credibility. Petitioner claims a work-related injury of Thursday, December 13, 2007. Petitioner did not identify any witnesses to this injury. He acknowledged he worked part if not all of the following day, despite worsening symptoms, and did not seek treatment until Monday, December 17, 2007. Petitioner and Todd Pirkins, Respondent's fleet manager, provided different accounts of the exchange they had following the safety meeting of December 18, 2007. Their accounts overlapped only to the extent they agreed Petitioner offered to resign.

Assessing credibility in this case is no easy task. Both witnesses were calm, likeable individuals. There were inconsistencies but they existed on both sides. Petitioner was inconsistent on the subjects of safety bonuses and meetings while Pirkins testified he was initially willing to plead Petitioner's case to "upper management" even though Petitioner supposedly told him he invented his accident. The events and conversations at issue took place six years earlier. A third person, i.e., Mike Moorehead, who might have served as a tiebreaker, did not appear at the hearing.

Petitioner argues that Pirkins "flip-flopped" when he recounted Moorehead's accusation, describing one time frame as to Moorehead's mindset on direct examination and another under cross. [See pages 100 and 113 of the transcript, with Pirkins using the phrase "this morning" on direct, arguably referencing the morning of December 18th, and "that morning," clearly meaning the morning of December 13th, under cross.] One problem with this argument is that Petitioner established the time frame himself, at the beginning of the hearing, when he testified he reported his claimed accident to Moorehead and a supervisor on Thursday, December 13th, shortly after the accident occurred. Another problem is that Pirkins made it clear he learned of the claimed December 13th accident on Monday, December 17th, the day before the meeting. Moorehead's accusation would have carried weight with Pirkins only if Moorehead had said that Petitioner reported being symptomatic when he arrived at work on December 13th.

The Arbitrator elects to side with Pirkins. Pirkins' lengthy recounting of the exchange was simply too detailed to have been invented. The Arbitrator also finds it significant that Pirkins turned toward Petitioner and addressed him directly while testifying. The Arbitrator finds it highly unlikely that Pirkins fabricated his version of the exchange. The fact that Petitioner offered to resign also gives the Arbitrator pause. If Petitioner was telling the truth, why would he offer to give up a job he very much needed? The Arbitrator also assigns weight to Pirkins' testimony that Respondent's bonus program was tailored to individual rather than group performance.

Did Petitioner sustain an accident on December 13, 2007 arising out of and in the course of his employment?

The Arbitrator, having found that Petitioner lacked credibility for the reasons stated above, finds that Petitioner failed to establish a compensable work accident of December 13, 2007. The Arbitrator views the remaining disputed issues as moot and makes no findings as to those issues.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Teresa Delgado,
Petitioner,

vs. NO. 10 WC 04584

15IWCC0064

Regis Corporation d/b/a BoRics Hair Care,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Petitioner herein and notice given to all parties, the Commission, after considering, the issues of accident, medical expenses, and Petitioner's permanent partial disability and being advised of the facts and law affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on December 9, 2013 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.

15IWCC0064

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $17,600.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JAN 2 3 2015

o-01/13/15
drd/wj
68

Daniel R. Donohoo

Charles J. DeVriendt

Ruth W. White

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

DELGADO, TERESA
Employee/Petitioner

Case# **10WC004584**

REGIS CORP D/B/A BoRICS HAIR CARE
Employer/Respondent

15IWCC0064

On 12/9/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.10% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0533 ROSS TYRRELL LTD
JIM TYRRELL
111 W WASHINGTON ST SUITE 1120
CHICAGO, IL 60602

1109 GAROFALO SCHREIBER HART ET AL
DANIEL L GRANT
55 W WACKER DR 10TH 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

Teresa Delgado,
Employee/Petitioner

v.

Regis Corp., d/b/a BoRics Hair Care,
Employer/Respondent

Case # **10** WC **4584**

Consolidated cases: **none**

15IWCC0064

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Peter M. O'Malley**, Arbitrator of the Commission, in the city of **Chicago**, on **9/10/13**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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 _____

15IWCC0064

FINDINGS

On **9/5/09**, 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 with respect to her right shoulder only.

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

Petitioner's current condition of ill-being with respect to her right shoulder ***is*** causally related to the accident, but her condition of ill-being with respect to her lower back ***is not*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**14,298.88**; the average weekly wage was $**274.98**.

On the date of accident, Petitioner was **50** 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 $**471.32** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**0.00** for other benefits, for a total credit of $**471.32**.

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 $274.98 per week for 1-6/7 weeks, commencing 3/25/10 through 4/6/10, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from 9/6/09 through 9/10/13, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall be given a credit of $471.32 for temporary total disability benefits that have been paid.

Respondent shall pay reasonable and necessary medical services relative to the right shoulder, as provided in Sections 8(a) and 8.2 of the Act. However, Petitioner's claim for medical expenses related to the low back is hereby denied.

Respondent shall pay Petitioner permanent partial disability benefits of $274.98 per week for 63.5 weeks, because the injuries sustained caused the 12.7% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

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

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

Signature of Arbitrator

11/26/13
Date

ICArbDec p. 2

DEC 9 - 2013

STATEMENT OF FACTS:

Petitioner sustained injuries that arose out of and in the course of her employment on September 5, 2009, when she slipped and fell on wet hair. The parties agreed that Petitioner sustained injuries to her right shoulder, and right hip. However, Petitioner's low back condition has been disputed by the Respondent.

Following the accident in question, Petitioner was seen at Christ Hospital and Medical Center on September 7, 2009. At that time, she was evaluated by both a nurse and an attending physician. With respect to her complaints, both the nurse and the attending physician, Dr. Felder, noted that she was complaining of pain in her right elbow, right shoulder and hip. Neither the nurse nor the attending physician noted that Petitioner had any type of pain in her low back at that time. At the time of this visit Dr. Felder examined Petitioner's back, noting that there was no tenderness and that she had a normal inspection. A neurological examination was also performed that indicated she had a normal gait, a normal motor examination and her sensory examination was normal as well. Following her examination, Petitioner was diagnosed with pain in her right shoulder, right hip, and right elbow, with a differential diagnosis of a contusion versus sprain/strain. She was released to return to work full duty at that time.

For her part, Petitioner testified that she noted an immediate onset of low back pain on September 5, 2009, that her low back pain was present on September 7, 2009 when she was seen at the emergency room at Christ Hospital, and that she complained of low back pain when she was examined. In terms of explaining why the records from Christ Hospital did not contain any notation of her having low back pain, she noted that her primary language is Spanish and that the emergency room physicians and nurses spoke to her in English.

On October 28, 2009, or almost two (2) months following the accident, Petitioner sought treatment with a Dr. Bustamante. At that time, she reported pain in her right elbow and right hip and also reported back pain. This was the first documented report of any back complaints contained in the medical records submitted at trial. She was diagnosed with multiple contusions, was referred for physical therapy and did not receive any work restrictions at that time.

On January 3, 2010, Petitioner was seen at Christ Hospital reporting right shoulder pain and low back pain. She underwent a MRI of the lumbar spine that revealed multilevel lumbar spondylosis with intervening degenerative disc disease and acquired spinal stenosis at L3-4 and L4-5. There was also small right L5-S1 facet joint effusion, but no other abnormalities were noted. That same day, she underwent a MRI of the right shoulder that revealed a near full thickness tear of the supraspinatus tendon and a partial tear of the infraspinatus tendon.

Following the diagnostic testing, Petitioner came under the care of Dr. Perez-Sanz who recommended surgery relative to her right shoulder. On March 25, 2010, Petitioner underwent an arthroscopic subacromial decompression, and a rotator cuff repair of the right shoulder. The postoperative diagnosis was impingement of the right rotator cuff.

Following surgery, Petitioner participated in physical. Petitioner testified that she continued to work full duty following the accident until her surgery for her right shoulder. She indicated that she participated in a program of physical therapy before being released to light duty work on April 6, 2010.

On April 30, 2010, or approximately eight (8) months following the accident, Petitioner was seen in the emergency room at Christ Hospital reporting lower back pain radiating into her right leg. According to the emergency room records, her back pain and right leg pain worsened the day before her admission into the emergency room. She was diagnosed with low back pain and sciatica, and received pain medications.

On July 8, 2010, Petitioner underwent a §12 examination with Dr. Mirkovic to address her low back condition. Dr. Mirkovic opined that Petitioner presented with subjective complaints of low back pain and lower extremity pain without any objective neurologic findings. He reviewed Petitioner's imaging studies and noted they were consistent with an underlying degenerative condition of the lumbar spine consistent with the aging process. With respect to the issue of causal connection, Dr. Mirkovic noted that the emergency room records from September 7, 2009 did not contain any suggestion that she had sustained an injury to her lower back as the physical examination of her low back and lower extremities, as well as the neurological examination, were unremarkable without any evidence of objective findings. Therefore, he noted there was a discrepancy between the medical records contemporaneous with the accident in question and Petitioner's history of events. In terms of her ability to return to work as it relates to the low back, he opined that it would be reasonable for her to return to work full time without restriction on a trial basis.

Following the §12 exam with Dr. Mirkovic, Petitioner continued to treat with Dr. Perez-Sanz through October 29, 2010. At that time Petitioner was discharged from care and was allowed to return to work full duty with the suggestion/modification that she use a low chair when cutting hair. Petitioner explained that a low chair simply means working with the chair at the lowest setting when cutting hair rather than raising same.

Petitioner testified that she continued to work in a light duty capacity for Respondent -- stocking product and cleaning the shelves –until she was released to work full duty in October of 2010. She testified that she then worked full duty until December of 2010 when she suffered a flare-up in her low back pain. Petitioner indicated that she has not returned to work for Respondent since and that she currently works as housekeeper at a rectory. In terms of cutting hair, she noted that she cuts her family members' hair, but no longer cuts hair on a professional basis.

With respect to her right shoulder complaints Petitioner noted that she currently has difficulty raising her right arm above her shoulder, is in constant pain as it relates to her right shoulder and has radiating pain from her shoulder to her right hand in the form of a burning sensation. In terms of her complaints as they relate to her low back Petitioner noted that presently her back pain was "bad," that she has pain radiating into her right leg as well as a burning sensation into the right leg and has difficulty sleeping.

WITH RESPECT TO ISSUES (C), DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF THE PETITIONER'S EMPLOYMENT BY THE RESPONDENT, AND (F), IS THE PETITIONER'S PRESENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner claims that she sustained an injury to her low back on September 5, 2009. Petitioner further claims that she noticed an immediate onset of pain in the low back at the time of her accident, that her low back pain was present when she was seen in the emergency room on September 7, 2009 and that she advised the emergency room personnel of her low back pain when she was seen at that time. Notwithstanding Petitioner's claims along these lines, the medical records from Christ Medical Center make no mention of any complaints with respect to her low back. To the contrary, the medical records indicate that two separate medical personnel, those being a nurse and a resident physician, questioned and examined Petitioner on that date and recorded no complaints of low back pain at that time. Instead, the record shows that Petitioner's complaints centered around her right elbow, right shoulder and her right hip. Further, the resident performed a physical examination of Petitioner's low back and performed neurological testing. The physical examination performed of her low back was negative for any complaints of low back pain. The neurological examination that was performed was also negative for any pain or issues stemming from her low back.

In an effort to explain why the initial medical records are silent as to any low back complaints, Petitioner noted that that her primary language is Spanish and that emergency room personnel conversed with her in English. However, on cross examination, Petitioner conceded that she is able to speak and is conversant in English, but that she "do[es] not know all the words." She also agreed that she had English speaking clients while working for Respondent and that she was able to converse with those individuals in English, although she claimed that it took a while. Therefore, the Arbitrator is not persuaded that the absence of any mention of any back pain complaints at the time of this initial visit can be so easily explained away by a possible language barrier, particularly in light of the fact that she had returned to light duty work and eventually full duty work on April 6, 2010, following surgery to her right shoulder and a program of physical therapy, before eventually visiting the Christ Hospital emergency room on April 30, 2010 with low back pain radiating into her right leg.

Accordingly, the Arbitrator finds that while Petitioner sustained accidental injuries arising out of and in the course of her employment on September 5, 2009 with respect to her right shoulder, and that her current condition of ill-being with respect to same is causally related to said accident, Petitioner failed to prove by a preponderance of the credible evidence that she sustained accidental injuries arising out of and in the course of her employment on September 5, 2009 with respect to her lower back and that she also failed to prove that her current condition of ill-being relative to her lower back is causally related to said accident. As a result, Petitioner's claim for compensation with regard to her lower back condition is hereby denied.

WITH RESPECT TO ISSUE (J), WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY AND HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner submitted medical bills relating to her hospitalization at Christ Medical Center on April 30, 2010. (PX6). The record shows that Petitioner was seen in the emergency room on that date for her low back condition only. In light of the Arbitrator's determination as to accident and causation (issues "C" and "F", supra), the Arbitrator finds that Petitioner failed to prove her entitlement to medical expenses relative to this emergency room visit for treatment for her low back. Accordingly, her claim for same is hereby denied.

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

As noted above, the Arbitrator determined that Petitioner failed to prove that she sustained accidental injuries relative to her low back, or that said injury was causally related to same. However, with respect to Petitioner's compensable right shoulder injury, the record shows that Petitioner underwent an arthroscopic procedure to her right shoulder to address a rotator cuff tear. She ultimately was released to return to work full duty, with a minor restriction that she was to use a chair at the lowest level rather than raising the same. Petitioner continued to work full duty for Respondent through December of 2010 when she suffered a flare-up in her low back pain. She currently works as housekeeper at a rectory and currently only cuts her family members' hair.

With respect to her right shoulder complaints Petitioner noted that she currently has difficulty raising her right arm above her shoulder, is in constant pain as it relates to her right shoulder and has radiating pain from her shoulder to her right hand in the form of a burning sensation. Therefore, based on the above, and the record taken as a whole, the Arbitrator finds that Petitioner suffered permanent partial disability to the extent of 12.7% person-as-a-whole pursuant to §8(d)2 of the Act and in light of the holding in *Will County Forest Preserve v. Workers' Compensation Commission*, 970 N.E.2d 16; 361 Ill. Dec. 16 (Ill.App. 3 Dist 2012; rehearing denied 7/5/12).

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 down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Diane Coleman,
Petitioner,

vs.

NO: 08 WC 17178

15IWCC0065

Illinois Department of Corrections,
Respondent,

DECISION AND OPINION ON REVIEW

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

The Commission finds that the Petitioner is entitled to7.5% loss of use to the person as a whole.

Petitioner was returned to her regular job and stopped getting treatment in September of 2008. The CT scan taken on March 25, 2008, was negative except for some degenerative narrowing at C5-C6. The MRI taken on June 12, 2008, did not show any disc herniations. (Petitioner Exhibit 3)

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $542.17 per week for a period of 37.5 weeks, as provided in §8(d)(2) of the Act, because the injuries sustained caused the loss of use to the person as a whole to the extent of 7.5%.

15IWCC0065

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

DATED: JAN 26 2015

Charles J. DeVriendt

Daniel R. Donohoo

Ruth W. White

HSF
O: 1/14/15
049

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

COLEMAN, DIANE
Employee/Petitioner

Case# **08WC017178**

03WC044922

IL DEPT OF CORRECTIONS
Employer/Respondent

15IWCC0065

On 9/11/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.03% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1357 RATHBUN CSEVENYAK & KOZOL
LUIS MAGANA
3260 EXECUTIVE DR
JOLIET, IL 60431

5132 ASSISTANT ATTORNEY GENERAL
STACEY LASKIN
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

1350 CENTRAL MGMT SERVICES RISK MGMT
WORKERS' COMPENSATION CLAIMS
PO BOX 19208
SPRINGFIELD, IL 62794-9208

0502 ST EMPLOYMENT RETIREMENT SYSTEMS
2101 S VETERANS PKWY*
PO BOX 19255
SPRINGFIELD, IL 62794-9255

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

SEP 11 2013

KIMBERLY B. JANAS Secretary
Illinois Workers' Compensation Commission

15IWCC0065

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

Diane Coleman
Employee/Petitioner

v.

Illinois Department of Corrections
Employer/Respondent

Case # 8 WC 17178

Consolidated cases: 03 WC 44922

An *Application for Adjustment 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 **August 20, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **March 25, 2008**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$62,400.00**; the average weekly wage was **$1,200**.

On the date of accident, Petitioner was **57** 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

Respondent shall pay to Petitioner permanent partial disability benefits of $542.17 /week for 50 weeks, because the injuries sustained caused the 10% loss of the person as a whole, as provided in Section 8(d)(2) of the Act.

Respondent shall pay reasonable and necessary medical expenses set forth in Petitioner's Exhibit 1 pursuant to the medical fee schedule, 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.

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

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

9-2-13
Date

SEP 11 2013

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Diane Coleman	)		
	)		
Employee/Petitioner	)	Case No.	08 WC 17178 C- 03 WC 44922
v.	)		
	)		
State of Illinois	)		
Department of Corrections	)		
	)		
Employer/Respondent	)		

Respondent's Proposed Findings of Fact and Conclusions of Law

An Application for Adjustment of Claim was filed in this matter. The case was heard by the Honorable Robert Falcioni, Arbitrator of the Workers' Compensation Commission, in the city of Chicago, on August 20, 2013. The Petitioner was represented by Luis Magana of Rathbun, Cservenyak, & Kozol. The Respondent was represented by assistant attorney general Stacey Laskin of the Illinois Attorney General's Office. After reviewing all of the evidence presented, the Arbitrator hereby makes the follow findings of fact and conclusions of law.

I. FINDINGS OF FACT

Petitioner, Diane Coleman, has been employed at Stateville Correctional Center for approximately 18 years as a classroom teacher, which requires that she spend up to three hours per day standing.

Petitioner testified that, on March 25, 2008, while teaching, she was beaten by an inmate. Petitioner completed an employee notice of injury form following the event. (Rx 6). On that form, Petitioner indicated that she injured her face, neck, head, back, hands,

and shoulders. *Id.* A supervisor also completed a report stating that Petitioner was punched several times resulting in unknown injuries. (Rx 7). A coworker completed a witness report and stated that she did not observe the attack but heard loud screaming and saw other employees restraining an inmate. (Rx 8)

Petitioner went by ambulance to the emergency room at Provena St. Joseph later the same day, complaining of right shoulder, right neck, back of head, and chest pain. (Px 3). She reported a past history of migraine headaches, ulcers/GERD, hypertension, and a right knee replacement. *Id.* Medical providers diagnosed blunt head trauma, blunt chest wall trauma, and a cervical strain. *Id.* A CT scan of the cervical spine revealed mild narrowing and degenerative changes at C5-C6 and was otherwise unremarkable. *Id.*

Following the accident, on March 26, 2008, Petitioner saw her primary care provider, Dr. Trevino. (Px 2). On April 2, 2008, Petitioner reported neck and upper back pain, trouble sleeping, crying spells, and headache. *Id.* On April 14, 2008, Petitioner returned to Dr. Trevino, still complaining of neck pain, difficulty sleeping, and migraine headaches, which she said had become more frequent. *Id.* Petitioner testified that her pre-existing migraine headaches had resolved prior to the March 2008 accident, after which they returned. During an April 28, 2008, visit with Dr. Trevino, Petitioner reported that her neck pain was slightly improved. *Id.* She complained of daily migraine headaches, helped by Imitrex. *Id.* Dr. Trevino examined Petitioner again on May 19, 2008, at which time Petitioner said she was sleeping well. (Px 5). Petitioner continued to complain of pain and migraine headaches. *Id.*

Petitioner underwent physical therapy at ATI from April 7, 2008, to June 18, 2008. (Px 5).

Petitioner saw Dr. Mataragas and his physician's assistant Christopher McGee on May 14, 2008, at which time she was advised to hold off on physical therapy until she could undergo an MRI to rule out neurocompressive disease. (Px 5). Petitioner was referred to an orthopedic doctor, Dr. Sanders, for her shoulder pain. *Id.*

Petitioner saw Dr. Sanders once for evaluation of her neck and shoulder injuries, on June 3, 2008. (Px 5). Petitioner reported pain in her neck, trapezius, and mid-back area since the March 25, 2008, work injury. *Id.* Dr. Sanders diagnosed soft tissue strain to the upper back and recommended that Petitioner continue treatment with Dr. Trevino. *Id.* Petitioner then visited Dr. Trevino monthly through at least October 2008, reporting improved pain symptoms over time. (Px 5).

Petitioner underwent MRI of the cervical spine on June 12, 2008, which showed focal disc changes at C2-C3 through C5-C6, congenital narrowing of the cervical spinal canal, and some limitation in imaging due to motion artifact. (Px 5).

Petitioner saw Dr. Mataragas on June 23, 2008, for cervical pain and radicular complaints. (Px 5). Dr. Mataragas ordered left-sided C5-C6 epidural steroid injections and advised Petitioner to follow up after she obtained the injections. *Id.*

Dr. Gashkoff administered epidural injections on August 13, 2008; September 9, 2008; and September 26, 2008. (Px 8). After evaluating Petitioner, he determined that she had a herniated nucleus pulposus of the cervical spine. *Id.*

Petitioner returned to PA Christopher McGee on November 7, 2008. (Px 8). Mr. McGee stated that Petitioner would start a new round of epidural injections. *Id.*

Records show that Petitioner did not have another injection until June 4, 2009. (Px 8). Dr. Gashkoff administered an additional injection on October 22, 2009. *Id.* The

records do not show any significant treatment related to the March 2008 work injury following this date.

On September 22, 2008, Petitioner underwent a functional capacity evaluation at ATI. (Px 4). The report indicates that Petitioner can perform at the medium demand level and is capable of lifting up to 50 pounds occasionally and 25 pounds frequently. *Id.* The report further states that Petitioner can perform her job as a teacher. *Id.*

Petitioner returned to work following the functional capacity evaluation. (Arb. Ex. 1).

On October 31, 2008, Respondent obtained a utilization review report regarding Petitioner's request for additional physical therapy, which was not certified after October 17, 2008. (Rx 3). The report indicates that 9 visits over 8 weeks would have been medically supported based on ODG Guidelines for treatment of cervicalgia. *Id.* The report further notes that the appropriateness of this guideline is confirmed by the findings on the September 22, 2008, functional capacity evaluation, indicating that Petitioner had achieved the capacity to perform medium physical demand level activities, which exceed the requirement for her work as a teacher. *Id.*

Respondent obtained an independent medical examination, conducted by Dr. An at Midwest Orthopaedics at Rush, on February 20, 2009. (Rx 2B). Dr. An diagnosed disc protrusion at C4-5 and C5-6 causing some central spinal stenosis with neck pain, bilateral radiculopathy, early signs of myelopathy with positive Hoffman's signs, and some numbness and tingling in the hands. *Id.* Dr. An recommended treatment with anti-inflammatory medication, physical therapy to strengthen the neck and shoulders, and surgery should Petitioner's condition not improve with conservative treatment. *Id.* He

opined that she should currently be able to work light to medium duty work, as she was doing. *Id.* He stated that her condition should plateau in about six weeks to maximum medical improvement. *Id.* He did not recommend any further injections because additional injections could potentially be dangerous. *Id.*

Petitioner testified that she cannot do highway driving at present because she has difficulty turning her neck. She further reported ongoing neck pains radiating down her shoulders and into her back. She stated that these symptoms do not limit her work at all and that she treats pain with over-the-counter medications. She reported a single recent incident of a freezing sensation in her hands, for which she has received no diagnosis or treatment.

II. CONCLUSIONS OF LAW

The Arbitrator makes the following conclusions of law:

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

The Arbitrator finds that all documented medical services provided for injuries sustained in the March 25, 2008, work injury were both reasonable and necessary. The Arbitrator awards payment of only those bills in Petitioner's Exhibit 1 for Provena St.

Joseph Hospital, Dupage Medical, Joliet Cardiology Center, Joliet Radiological, and ATI Physical Therapy. (Px 1).

The evidence of record does not establish that bills from Orland Park Ortho for a service date of November 12, 2010, and labeled as related to knee pain, are causally related to this claim.

Petitioner has failed to meet her burden of proof with regard to bills not tendered as evidence. Respondent must pay documented bills directly to the providers. (Px 1).

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

Petitioner presented no evidence that she sustained any permanent injury to the bilateral hands, head, or eyes related to the March 25, 2008, work injury.

Petitioner continues to work full duty as a teacher. She testified that she has some neck pain and difficulty turning her head, which affects her ability to drive on highways. Petitioner uses over-the-counter medications to treat her pain. Petitioner underwent conservative treatment for her injuries and was off work for approximately six months. Objective testing noted abnormalities at two levels of her cervical spine, and she received extensive and substantial treatment for this condition, as well as receiving a recommendation for a cervical fusion surgery, which she has to date, declkined. Accordingly, the Arbitrator finds that Petitioner has sustained injuries equivalent to a10% loss of use of the person as a whole pursuant to Section 8(d)(2).

Arbitrator Robert Falcioni

Date

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

DOMINIQUE FLENARD n/k/a
GABRIELLA KARTEIR,
Petitioner,

15IWCC0066

v. No: 09WC6555

CEQUR SECURITY,
Respondent.

DECISION AND OPINION ON PETITION UNDER §8(a)

This matter comes before the Commission on Petitioner's Petition for relief under §8(a) of the Act. A hearing was held before Commission White on June 20, 2014 in Chicago. No testimony was adduced, but Petitioner's lawyer represented that the medical bills of Dr. Merriman, both prior and subsequent to the settlement, had not been paid. The compensability of Dr. Merriman's bills is the only issue before the Commission.

The Commission approved a settlement contract in the underlying case on August 16, 2012. The total settlement payment was $50,328.00, representing loss of 45% of the person-as-a-whole based on an alleged work-related back injury. The contract includes standard language that the settlement includes all medical expenses both current and future for which Petitioner is responsible. However, the last sentence of the settlement language provides: "Petitioner shall retain all rights under Section 8(a) for reasonable, necessary, and related treatment involving the lumbar spine and including her spinal cord stimulator."

In a letter dated December 13, 2013, Dr. Merriman wrote to Petitioner's lawyer seeking assistance in receiving payment for psychological treatment she had been rendering to Petitioner. Dr. Merriman indicated her treatment "addressed symptoms of depression related to her back injury and resultant pain and physical limitations."

In a letter dated January 23, 2014 Petitioner's general practitioner, Dr. Buvanendran, whose bills Respondent stipulated are compensable, wrote to Petitioner's lawyer. He reported that Petitioner was experiencing increased left arm weakness and he was going to order an EMG. He also noted that Petitioner was "also seeing Dr. Merriman, the psychologist on staff [at his medical facility], as part of [their] treatment for her back issues."

15IWCC0066

Respondent refused to pay the psychological treatment because it "does not involve the lumbar spine." Therefore those expenses are not compensable under the unambiguous language of the settlement contract. It notes that Petitioner was being treated by Dr. Merriman prior to the settlement and those expenses had been denied prior to the settlement contract. Respondent asserts "it was the specific intent of the parties at the time of settlement to separate Petitioner's accepted lumbar spine injuries and disputed psychological injuries." Petitioner argues the psychological treatment stems directly from her lumbar injury and therefore should be compensable under the contract.

Generally, psychological counseling would be compensable if part of a multi-disciplinary pain treatment regimen for a compensable injury. In addition, in this case both Dr. Merriman and Dr. Buvanendran have offered the opinion that the need for such counseling was caused by the lumbar injury. However, also in this case, the language of the contract specifically provides that Respondent would be responsible for only "treatment involving the lumbar spine and including her spinal cord stimulator." It would seem that such language would preclude psychological treatment even if such treatment was precipitated by the lumbar injury. The inclusion of such specific language would appear to negate Respondent's responsibility for any other treatment.

The Commission finds that at the time of the settlement contract Petitioner was, or at least should have been, aware that there would be a problem in collecting the expenses for psychological treatment because Respondent had denied those expenses prior to the settlement. Certainly, in order to have such treatment included it should have been specified in the terms of the settlement contract, or at least the language specifically limiting treatment should not have been included. The Commission concludes that under the clear language of the contract Respondent is not responsible for psychological treatment even if such treatment may have been precipitated by the work-related injury. Therefore, Petitioner's petition is denied.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's Petition for relief Under Section 8(a) of the Act is denied.

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

DATED: JAN 27 2015

Ruth W. White

Daniel R. Donohoo

Charles J. DeVriendt

RWW/dw
R-6/20/14
46

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

Yesenia Donato,

Petitioner,

vs.

NO. 11 WC 17000
13 WC 22535

Sam's Club,

15IWCC0067

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 22, 2014 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 $7,300.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JAN 2 7 2015
SJM/sj
o-1/22/2015
44

Stephen J. Mathis

David L. Gore

Mario Basurto

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

DONATO, YESENIA
Employee/Petitioner

Case# **11WC017000**

13WC022535

15IWCC0067

SAM'S CLUB
Employer/Respondent

On 4/22/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% 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:

2553 LAW OFFICE OF JAMES P McHARGUE
MATTHEW C JONES
123 W MADISON ST SUITE 1000
CHICAGO, IL 60602

0560 WIEDNER & McAULIFFE LTD
JUSTIN T SCHOOLEY
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Yesenia Donato
Employee/Petitioner

v.

Sam's Club
Employer/Respondent

Case # 11 WC 17000

Consolidated cases: 13WC22535

An *Application for Adjustment 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 **03-19-14**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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, **02-24-11**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $ **24,549.72**; the average weekly wage was $ **472.11**.

On the date of accident, Petitioner was **36** 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 $ **3,147.50** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**0.00** for other benefits, for a total credit of $ **3,147.50**.

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 $ 314.72/week for 10 weeks, commencing 02-25-11 through 05-05-11, as provided in Section 8(b) of the Act.

Respondent shall be given a credit of $ 3,147.50 for temporary total disability benefits that have been paid.

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $ 301.94 to Chicago Orthopedics and Sports Medicine, $ 912.29 to Industrial Pharmacy Management, $ 101.70 to Medicos Pain & Surgical, and $ 5,886.16 to Marque Medicos as provided in Sections 8(a) and 8.2 of the Act.

Respondent's liability for any additional medical expenses is denied.

Respondent's liability for prospective medical treatment including a left shoulder arthroscopy is denied.

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

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

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

Signature of Arbitrator

04-21-14
Date

ICArbDec19(b)

APR 22 2014

Donato, Yesenia v. Sam's Club
IWCC No. 11 WC 17000; 13WC 22535

STATEMENT OF FACTS

As of February 24, 2011, Petitioner was a 36-year-old single female with zero dependent children who had been employed with Sam's Club as a cake decorator since approximately May 1, 2003. On February 24, 2011, she sustained a compensable accident and provided proper notice of the same (claim 11 WC 17000). Issues in dispute with respect to claim 11 WC 17000 at the time of the March 19, 2014 hearing include 1) causation, 2) unpaid medical bills, 3) TTD, and 4) prospective medical treatment including a left shoulder arthroscopy.

Petitioner also alleges a January 17, 2013 accident arising out of and in the course of her employment (claim 13 WC 22535). Issues in dispute with respect to claim 13 WC 22535 include 1) accident, 2) notice, 3) causation, 4) unpaid medical bills, 5) TTD, and 6) prospective medical treatment including a left shoulder arthroscopy.

Petitioner initially sought treatment at Marque Medicos on February 25, 2011. She reported pain in her bilateral wrists, left shoulder, and left neck, along with right hand numbness. Petitioner associated her symptoms with her job duties as a cake decorator.

At trial, petitioner testified that her job duties included taking cakes out of a freezer; obtaining decorating supplies; placing cakes on racks to thaw; and icing cakes. (T. 9). Petitioner testified that 4 cakes in a box weighed approximately 14 pounds. (T. 11). Petitioner testified that she spent 10-15 minutes of her day removing cakes from the freezer, and that after removing 5-6 cakes from above shoulder height, boxes were then at chest level. (T. 13, 41). Petitioner testified that she thereafter proceed to ice cakes situated at chest height. (T. 13). Petitioner testified that any overhead work performed while icing cases was performed with her right arm, not her left, and that the pastry bags used to ice the cakes weighed 1-2 pounds. (T. 14). Petitioner testified that she spent 5-6 hours per day decorating cakes. (T. 14).

Cervical spine X-rays on February 25, 2011 revealed a reversal of the cervical lordosis with an anterior translation of the head, most likely indicative of muscle spasm and/or soft tissue injury. Right wrist and left shoulder X-rays were negative. Chiropractor Perez diagnosed neck pain, left shoulder pain, and right wrist sprain/strain. He recommended physical therapy, ordered petitioner off of work, and referred her to Dr. Andrew Engel of Medicos Pain and Surgical Specialists.

Petitioner thereafter attended treatment at Marque Medicos approximately three times per week and commenced care with Dr. Engel on March 3, 2011. Dr. Engel recommended a left shoulder MRI and opined that petitioner's left shoulder was responsible for her neck pain.

A March 10, 2011 left shoulder MRI demonstrated supraspinatus tendinopathy and Type II acromion. No tears were identified.

Petitioner continued to regularly attended treatment at Marque Medicos, and on March 31, 2011, Dr. Engel referred petitioner to Dr. Nam for further evaluation of her shoulder. She was to remain off work and continue with physical therapy and pain medication.

On April 11, 2011, petitioner presented to Dr. Nam and reported left shoulder symptoms. Dr. Nam reviewed the left shoulder MRI, noting some supraspinatus tendinopathy with no tearing. He diagnosed left shoulder pain with impingement syndrome and administered a cortisone injection.

Petitioner returned to Dr. Engel on April 28, 2011 reporting pain at 2/10 pain. She advised that her wrist pain had completely resolved. Petitioner was to continue treating with Dr. Nam and return to work with no lifting greater than ten pounds.

On May 3, 2011, petitioner underwent a Section 12 examination with Dr. Michael Grear. (R.x2, Ex.2). Dr. Grear reviewed the left shoulder MRI, noting no evidence of any significant structural abnormalities. Physical examination revealed full, unrestricted range of motion of the left shoulder, with no palpable discomfort about the AC joint or rotator cuff. Petitioner also had full range of motion of the cervical spine and bilateral wrists. Dr. Grear diagnosed a resolved strain of the cervical spine and left rotator cuff, and resolved capsulitis of the right wrist. Dr. Grear opined that petitioner's treatment was appropriate and causally related to the repetitive nature of her job duties. That said, he opined that petitioner had reached MMI; required no further treatment; and could return to work full duty without restrictions.

Petitioner testified that she returned to work on approximately May 5, 2011 as a packer, where her job duties included packing racks of bread. (T. 23). Petitioner testified that grabbing bread required her to reach "down below you," after which she placed it on a table. (T. 43).

On May 9, 2011, petitioner returned to Dr. Nam, reporting that her left shoulder was doing well. Dr. Nam recommended work restrictions of no lifting greater than ten pounds and no overhead lifting with the left arm. Petitioner was to continue physical therapy.

Petitioner thereafter continued to regularly treat with Dr. Engel and Dr. Nam, and undergo chiropractic care/physical therapy at Marque Medicos. On June 6, 2011, Dr. Nam recommended postponing physical therapy and recommended a trial of full duty work.

Petitioner testified that at this point, she returned to work in the deli at Sam's Club, where she worked from June 2011 "to date." (T. 24, 44). She tested that her job duties in this position included preparing ready to eat foods and stocking and cleaning the deli. (T. 25). Petitioner testified that she has limited her lifting in this position, and that respondent accommodated her restrictions. (T. 25, 27-28). She testified that if she is required to lift any heavy boxes, assistance is provided. (T. 48-49).

Dr. Nam then authored a report on July 11, 2011, indicated that petitioner was returned to work full duty for left shoulder impingement and was discharged from care.

On July 21, 2011, petitioner returned to Dr. Engel reporting pain at 1/10. Dr. Engel recommended an FCE to determine whether petitioner was a good candidate for a work conditioning program, but in the meantime, noted that petitioner could continue full duty work.

Thereafter, on September 8, 2011, Dr. Engel recommended undergoing an MRI of the cervical spine, holding off on the FCE, and continuing over the counter medication with home exercise. An MRI of the cervical spine on October 5, 2011 revealed minimal disc bulging at C5-C6 and C7-T1 without central canal or neuroforaminal stenosis.

On October 12, 2011, Dr. Engel reviewed the MRI and discussed C4, C5, and C6 medical branch blocks. Injections were administered on October 26, 2011.

Dr. Engel's November 10, 2011 report suggests that petitioner experienced left neck pain radiating to her shoulder, but at trial petitioner testified that her symptoms went from her shoulder to her neck, not her neck to her shoulder. (T. 42). Additional medial branch blocks at C4, C5 and C6 were administered on December 1, 2011.

On January 4, 2012, petitioner then underwent left C4, C5 and C6 medial branch radiofrequency ablations on January 4, 2012.

As of January 19, 2012, additional therapy, over-the-counter medication and restricted work were recommended. Treatment resumed at Marque Medicos on January 24, 2012. Petitioner thereafter continued to regularly follow up with Dr. Engel while continuing treatment at Marque Medicos as well. On March 8, 2012, Dr. Engel referred petitioner to Dr. Erickson with therapy being placed on hold until evaluation.

On April 13, 2012, petitioner presented to Dr. Erickson, whose record notes neck pain radiating from the upper third of her trapezius towards her left shoulder, again inconsistent with petitioner's testimony at trial. Regardless, pain was reported at 2/10. Dr. Erickson noted that petitioner's October 5, 2011 MRI revealed very small abnormalities including a tiny irregular disc bulge at C3-4, a small bulge at C5-6, and a small disc herniation at C7-1. Dr. Erickson confirmed that petitioner had returned to work full time with restrictions including no overhead activities or repetitive lifting. Dr. Erickson recommended that petitioner avoid surgery, but encouraged conservative management.

Subsequent treatment discussions included a possible cervical discography, but in light of petitioner's gradual improvement, Dr. Erickson maintained that as of July 25, 2012, petitioner was not a surgical candidate. He increased petitioner's restrictions to 20 pounds lifting frequently and 25 pounds lifting occasionally.

In contrast to petitioner's medical records, petitioner testified at trial that her restrictions were not increased until October 2012, after which she experienced increased pain. (T. 29, 30). Medical records further reflect that when petitioner returned to Dr. Engel on August 16, 2012, she reported pain at 1-2/10 and indicated that she was in a new work position, which is why she felt better. Petitioner testified that in August 2012, she was performing stocking activities while working the deli department. (T. 45). Dr. Engel noted petitioner's discharge from care by Dr.

Erickson with permanent restrictions. Petitioner was to continue restricted work duties and return in two months.

On September 18, 2012, petitioner was reevaluated by Dr. Grear. (R.x2, Ex.3) Upon presentation, she reported that she was working in a different capacity preparing meals, which did not require any overhead activities. Petitioner advised that her symptoms had dissipated to the point where she was extremely pleased and was asymptomatic. Petitioner reported no current pain in the shoulders or weakness in the upper extremities.

Dr. Grear diagnosed resolved impingement syndrome of the left shoulder and resolved strain of the cervical spine with no evidence of any objective pathology of the shoulder or cervical spine. He opined that the recommendation of Dr. Nam for continued physical therapy through July 11, 2011 was appropriate, but did not believe the radial ablation procedures were medically necessary as they were palliative in nature. He opined petitioner would have reached MMI on July 11, 2011, but found that no lifting over 25 pounds or repetitive overhead activity and no repetitive motion on a permanent basis would be appropriate with the intermittent use of non-steroidal anti-inflammatory over-the-counter medication.

On October 18, 2012, petitioner returned to Dr. Engel again reporting pain between 1-2/10. Again in contrast to her testimony at trial, petitioner reported no increased pain with her new position at work. Dr. Engel's diagnosis was cervical facet syndrome and cervical herniated disc. Petitioner was discharged from pain management and was to continue permanent restrictions. She would continue home exercises and over the counter medications.

On January 17, 2013, petitioner then returned to Dr. Engel, reporting additional left neck and left shoulder pain. Petitioner suggested that due to her co-workers calling off, she had increased her workload and was forced to leave work secondary to pain. Dr. Engel's report suggests that petitioner's new job was repetitive and included stocking the deli and entering a cold room with heavy lifting. Dr. Engel recommended resuming physical therapy and being taken completely off work.

Thereafter, on January 31, 2013, Dr. Engel opined that he did not believe petitioner's neck pain was causing her symptoms, but rather, believed that her problems emanated from the left shoulder. As such, he recommended treatment with Dr. Sclamberg. Petitioner was to transition to a home exercise program and return to work with restrictions.

Petitioner presented to Dr. Sclamberg on February 21, 2013 reporting a two-year history of left shoulder pain. Dr. Sclamberg noted that petitioner's prior MRI from March 2011 demonstrated supraspinatus tendonitis with impingement syndrome. He diagnosed impingement syndrome of the left shoulder causally related to petitioner's work. He recommended an arthroscopy with subacromial decompression, an evaluation of the rotator cuff, and possible rotator cuff repair. Petitioner was to hold off on any physical therapy and continue a 10-pound lifting restriction.

During follow up with Dr. Sclamberg on April 2, 2013, petitioner reported a 75% improvement in her condition.

On April 30, 2013, Dr. Joy Hamilton signed off on a utilization review report addressing petitioner's medical treatment to date, as well as the prospective shoulder surgery recommended by Dr. Sclamberg. The report reflects that there were no indications for the following treatment:

- 2/25/11 cervical spine X-rays
- 2/25/11 left shoulder X-rays
- 2/25/11 right wrist X-rays
- 3/10/11 left shoulder MRI
- 10/5/11 MRI of the cervical spine
- Chiropractic and physical therapy treatment after 3/19/11
- Mobic after 4/13/12
- Soma
- Omeprazole
- Ultram or Tramadol
- 4/13/12 evoked potential study
- 10/26/11 medial branch block
- 12/15/11 confirmatory medial branch block
- 1/4/12 medial branch ablation

Dr. Hamilton opined that petitioner had no clinical findings to suggest serious pathology.

Dr. Hamilton also recommended denial of any surgical procedures to the shoulder, as petitioner had no defined surgical lesion or any clinical findings correlating with her diagnostic imaging. Dr. Hamilton found petitioner's symptoms had remained mild and clinical examination findings had been minimal, with no specific functional deficits.

On November 4, 2013, Dr. Sclamberg testified that petitioner was employed by Sam's Club as a "laborer." (P.x11, p. 24). He testified that petitioner required left shoulder surgery which was necessitated by her employment with respondent as of 2011. Dr. Sclamberg testified that he did not have an understanding of how much weight petitioner was required to lift at her employment or how often she would be required to lift the same. (P.x11, p. 36).

On January 17, 2013, Dr. Grear testified that that petitioner had reached MMI as of July 2011 and that no further treatment after said date was warranted. He testified that any of the additional treatment rendered by the physicians at Marque Medicos and Medicos Pain & Surgical Specialists after July 2011 was palliative in nature and not medically required to cure or alleviate petitioner's symptoms. Dr. Grear further testified that overhead activity is a more initiating even than below the shoulder activity and that less strain is placed on the rotator cuff if performing activities at waist level. (R.x2, p.13-14).

Petitioner testified that the only time she had a driving restriction was when she was on sedatives due to injections, and that she has otherwise been capable of driving. (T. 48-49).

Claim 11 WC 17000

In support of the Arbitrator's Decision relating to causation ("F"), the Arbitrator finds the following facts and makes the following conclusions of law:

The Arbitrator finds that petitioner's current condition of ill-being is not related to her February 24, 2011 accident. In support of such conclusion, the Arbitrator finds the opinions of Dr. Grear more credible than those of the physicians of Marque Medicos, Medicos Pain & Surgical, and Dr. Sclamberg.

In that regard, petitioner testified that when performing her cake decorating job duties, she spent only 10-15 minutes per day carrying boxes of cakes that weighed approximately 14 pounds. Further, after removing 5-6 cakes from a freezer, the remainder of petitioner's job duties were performed primarily at chest level or below, with any overhead work being performed by petitioner's right upper extremity – i.e. her uninjured arm. In addition, the Arbitrator notes that any additional force required to lift a 1-2 pound pastry bag would be insignificant.

During his deposition, Dr. Grear credibly testified in accordance with his September 18, 2012 report wherein he diagnosed resolved impingement syndrome of the left shoulder and a resolved strain of the cervical spine. As September 18, 2012, petitioner had no objective pathology of the shoulder or cervical spine was seen at that time.

Dr. Grear further testified that overhead activity is a more initiating event of shoulder pathology than below the shoulder activity, with less stress being placed on the shoulder when performing activities at waist level. Further, he testified that the weight of items being carried is a factor when assessing causation.

Petitioner testified that since she returned to modified work in May 2011, her job duties included reaching to grab bread below her and placing it on a table. Further, since transitioning to a deli position, petitioner testified that from June 2011-to date, petitioner has limited her lifting and if any heavy lifting is required, she obtains assistance. As such, petitioner's own testimony at trial establishes that her employment would not be an initiating event of her current condition of ill being.

The Arbitrator also notes that petitioner's testimony at trial was directly contradicted by the subjective histories provided to her medical providers. Petitioner testified that when her restrictions were increased, she experienced increased in pain. However, petitioner's medical records reflect that when her restrictions were increased, she informed her physicians that she had transitioned to a new work position which is why she experienced improvement in her condition. Further, when she presented to Dr. Grear on September 18, 2012, petitioner maintained that she was working in a different capacity and that her symptoms had dissipated to a point where she was extremely pleased and asymptomatic.

In reaching this conclusion, the Arbitrator also notes that on July 11, 2011, Dr. Nam indicated that petitioner was returned to work full duty for left shoulder impingement and was discharged from care.

The Arbitrator further finds that the events leading up to or on January 17, 2013 did not further aggravate petitioner's symptoms stemming from the February 24, 2011 work accident, as petitioner testified that from June 2011-to date, her job duties had remained constant.

In finding Dr. Grear more credible than Dr. Sclamberg, the Arbitrator also notes that Dr. Grear knew that petitioner was a cake decorator and not a "laborer" as described by Dr. Sclamberg.

Based on the aforementioned, causal connection after July 11, 2011 is denied.

In support of the Arbitrator's Decision relating to unpaid medical bills ("J"), the Arbitrator finds the following facts and makes the following conclusions of law:

The Arbitrator incorporates the above findings and conclusions, and reiterates that the opinions of Dr. Grear are most credible and that petitioner's current condition is not related to the February 24, 2011 work accident. As such, the Arbitrator finds that respondent is not liable for any medical expenses after July 11, 2011.

In that regard, Dr. Grear found physical therapy through July 11, 2011 appropriate, but did not believe that petitioner required the radial ablation procedures. Based on the aforementioned, the Arbitrator orders that respondent satisfy the following medical expenses in accordance with respondents fee schedule exhibit 3:

- Chicago Orthopedics and Sports Medicine - $301.94
- Industrial Pharmacy Management - $912.29 (to be reduced pursuant to the Fee Schedule)
- Medicos Pain & Surgical - $101.70
- Marque Medicos - $5,886.16

Respondent's liability for any additional medical expenses is denied.

In support of the Arbitrator's Decision relating to TTD ("L"), the Arbitrator finds the following facts and makes the following conclusions of law:

Petitioner claims to be entitled to TTD from 02-25-11 to 05-05-11 and 01-17-13 to 01-31-13, representing 12 weeks of TTD. The Arbitrator incorporates the above findings and conclusions and further finds that petitioner is entitled to TTD from only 02-25-11 to 11-05-11. In so finding, the Arbitrator reiterates that he finds Dr. Grear most credible; that petitioner had reached MMI as of July 11, 2011; and that her current condition of ill-being is not related to the 02-24-11 work accident.

Based on the aforementioned, respondent shall pay petitioner TTD from 02-25-11 to 05-05-11 representing 10 weeks ($3,147.40) and receive credit for the $3,147.50 in TTD previously paid.

In support of the Arbitrator's Decision relating to prospective medical treatment ("K"), the Arbitrator finds the following facts and makes the following conclusions of law:

The Arbitrator incorporates the above findings and conclusions, reiterating that he finds Dr. Grear most credible; that on July 11, 2011, Dr. Nam indicated that petitioner was returned to work full duty for left shoulder impingement and was discharged from care; that petitioner reached MMI as of July 11, 2011; and that her current condition of ill-being is not related to the 02-24-11 work accident.

Based on the aforementioned, petitioner's request for prospective medical treatment including a left shoulder arthroscopy is denied.

Claim 13 WC 22535

In support of the Arbitrator's Decision relating to accident ("C"), the Arbitrator finds the following facts and makes the following conclusions of law:

The Arbitrator finds that petitioner did not sustain an accident arising out of and in the course of her employment on January 17, 2013. In so finding, the Arbitrator notes that petitioner testified that since June 2011, she had performed essentially the same job duties and failed to testify to any identifiable work accident that occurred on January 17, 2013. Petitioner's medical records also do not reflect a January 17, 2013 accident arising out of and in the course of her employment.

In support of the Arbitrator's Decision relating to notice ("E"), the Arbitrator finds the following facts and makes the following conclusions of law:

Although petitioner testified that she that in January 2013 she informed her supervisor that she would be off of work because of her shoulder, petitioner, on direct examination, did not testify that she informed her supervisor of a work accident as required by Section 6 of the Act. As such, the Arbitrator finds that petitioner failed to provide proper notice of her work accident as alleged, as this is the only evidence presented as to proper notice.

In support of the Arbitrator's Decision relating to causation ("F"), the Arbitrator finds the following facts and makes the following conclusions of law:

The Arbitrator incorporates the findings and conclusions of C and E, and in light the Arbitrator's denial of accident and notice, causation is denied as well. Further, although the Arbitrator finds the opinions of Dr. Grear most credible, the Arbitrator further notes that Dr. Sclamberg testified that petitioner's need for additional treatment as of February 2013 was necessitated by her employment with respondent as of 2011, not any alleged accident in January 2013.

In support of the Arbitrator's Decision relating to unpaid medical bills ("J"), the Arbitrator finds the following facts and makes the following conclusions of law:

The Arbitrator incorporates the findings and conclusions from C, E, and F and further concludes that based on a denial of accident, notice and causal connection, respondent has no liability for unpaid medical bills. This conclusion does not affect the Arbitrator's conclusion regarding liability for unpaid medical bills in petitioner's corresponding claim 11 WC 17000.

In support of the Arbitrator's Decision relating to TTD ("L"), the Arbitrator finds the following facts and makes the following conclusions of law:

As accident, notice, and causation are denied, respondent's liability for TTD claimed by petitioner is denied as well.

In support of the Arbitrator's Decision relating to prospective medical treatment ("K"), the

Arbitrator finds the following facts and makes the following conclusions of law:

As accident, notice, and causation are denied, petitioner's request for prospective medical treatment including a left shoulder arthroscopy is denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Deborah Sands,

Petitioner,

vs.

NO: 10 WC 13465

15IWCC0068

Silverleaf Resorts, Inc.,

Respondent.

DECISION AND OPINION ON REVIEW

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

The Arbitrator found that "at most, petitioner sustained a strain/sprain of her right knee on April 18, 2008, that resolved by April 30, 2008, at the earliest and at the latest by September 7, 2008, when she was returned to work full duty by her treating orthopedic surgeon." In the order part of the Decision, the Arbitrator awarded no benefits "because petitioner failed to prove by a preponderance of the credible evidence that her current condition of ill-being is causally related to a work-related injury allegedly sustained on April 18, 2008." Further, on page 19 of the Decision the Arbitrator stated with respect to the medical bills: "The Arbitrator finds that the Petitioner did not meet her burden of proving by a preponderance of the credible evidence that any of the submitted medical bills were for treatment that was causally related to the April 18,

2008, work accident." Yet the last sentence on page 19 states: "The Arbitrator further finds that petitioner has proved that the treatment she received from April 24, 2008, through September 7, 2008, was causally related to injuries she received on April 18, 2008."

Petitioner submitted into evidence the medical bills she incurred from April 24, 2008, through September 9, 2008. The Commission finds that these bills, which were paid by Petitioner's prior employer, Blue Green Vacations Unlimited, are Respondent's responsibility.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 29, 2013, is hereby modified as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall hold Petitioner harmless from any claims for reimbursement by Blue Green Vacations Unlimited or its workers' compensation carrier in connection with the medical bills in evidence Petitioner incurred from April 24, 2008, through September 9, 2008.

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: JAN 2 7 2015
SM/sk
o-1/15/2015
44

Stephen J. Mathis

Mario Basurto

David L. Gore

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

SANDS, DEBORAH
Employee/Petitioner

Case# **10WC013465**

09WC009984

15IWCC0068

SILVERLEAF RESORTS
Employer/Respondent

On 8/29/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.06% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0365 BRIAN J McMANUS & ASSOC LTD
MARK CONNOLLY
30 N LASALLE ST SUITE 2126
CHICAGO, IL 60602

0507 RUSIN MACIOROWSKI & FRIEDMAN LTD
MICHAEL MOORE
10 S RIVERSIDE PLZ SUITE 1530
CHICAGO, IL 60606

FINDINGS

On the date of accident, 04-18-08, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $32.454.76; the average weekly wage was $624.13.

On the date of accident, Petitioner was 47 years of age, single, 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

Denial of benefits

No benefits are awarded because petitioner failed to prove by a preponderance of the credible evidence that her current condition of ill-being is causally related to a work-related injury allegedly sustained on April 18, 2008.

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.

Signature of Arbitrator

8·26·13
Date

AUG 29 2013

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
19(b)

15IWCC0068

Deborah Sands
Employee/Petitioner

Case # 10 WC 13465

v.

Consolidated cases: 09 WC 9984

Silverleaf Resorts
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 Arbitrator Kurt Carlson, Arbitrator of the Commission, in the city of Wheaton, on 5/29/13. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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 _____

I. FINDINGS OF FACT

This case involves a right knee accident that allegedly occurred on April 18, 2008. The parties stipulated that the accident was unwitnessed and was first reported to respondent three days later.

Prior Accident

On September 1, 2007, petitioner injured herself while working for Blue Green Vacations when her left foot got tangled up in a tablecloth on a booth causing her to fall and land on "all fours," but striking the street with her right knee first. (Tr. Pp. 11-12). She immediately reported this accident to her supervisor and she was treated at the scene. (Tr., pp. 13-14).

Petitioner testified that her problems with her left leg, her wrists and her palms healed a couple of months later. (Tr., p. 55-56) The petitioner's right leg continued to bother her. In fact, when petitioner stopped working for Blue Green Vacations she still had pain and numbness in her right leg and continued to be on restricted work. (Tr., p. 17)

Petitioner began working with Silverleaf Resorts and performed a similar job. (Tr., p. 18) Silverleaf was able to accommodate petitioner's work restrictions. (Tr., p. 18)

Accident

Petitioner testified that on April 18, 2008, while working for Silverleaf she was lifting up a prize wheel to put onto a table when she twisted her right knee and hurt her lower right back. (Tr., pp. 20-21) Again, the parties stipulated that the occurrence was unwitnessed.

Initial Medical Treatment

Petitioner first sought treatment on April 24, 2008, with Dr. Anderson at which time she reported bilateral knee pain and numbness, and that the numbness was getting worse. (Tr., p. 23) Dr. Anderson had already been treating the petitioner for her earlier accident. He did not change petitioner's work restrictions (Tr., p. 23). No history of a new accident is in Anderson's records.

First History of Accident

Petitioner's next contact with a medical care was on April 28, 2008, when she called Fox Valley Orthopedics and gave a history of her September 1, 2007, work accident and of her April 18, 2008 occurrence.

On May 9, 2008, petitioner was seen at Fox Valley Orthopedics and complained that her right knee injury resulting from her September 1, 2007, work accident was "aggravated" on April 18, 2008, "while lifting and twisting."

Petitioner attributes right knee problems to the earlier accident

Despite the above, petitioner consistently attributed her right knee pain to the earlier occurrence on September 1, 2007.

For instance, at CoSport Physical Therapy from May 20, 2008, through August 15, 2008, the April 18, 2008, work accident was never referenced, but the September 1, 2007, work accident was documented.

On September 25, 2008, petitioner gave a history to Dr. Pesche at Fox Valley Orthopedics in which she denied any specific injury to her knees other than the fall onto her knees one year prior [on September 1, 2007].

The Arbitrator notes that petitioner received care from Provena St. Joseph Hospital from September 16, 2008, through July 28, 2009, during which time her alleged April 18, 2008, work accident was never referenced and petitioner attributed her right leg problems to the September 1, 2007, occurrence.

The Arbitrator notes that petitioner received care from Dr. Mokwe from October 30, 2008, through November 10, 2010, during which time her alleged April 18, 2008, work accident was never referenced, instead attributing her right leg problems were to the earlier September 1, 2007 event.

The Arbitrator notes that petitioner received care from Associates in Psychiatry and Counseling from December 1, 2008, through February 28, 2011, during which time neither her alleged April 18, 2008, work accident nor her September 1, 2007, work accident were ever referenced.

The Arbitrator notes that petitioner received care from Delnor Community Hospital from May 5, 2009, through August 22, 2012, during which time her alleged April 18, 2008, work accident was never referenced and her right leg problems were attributed to the September 1, 2007 accident on two occasions.

The Arbitrator notes that petitioner received care six times from Lake Cook Orthopedics from June 27, 2009, through October 28, 2009, during which time the April 18, 2008, work accident was never referenced, instead, her right leg problems were attributed to the September 1, 2007, work accident on two occasions.

The Arbitrator notes that on October 29, 2009, petitioner informed Lake Cook Orthopedics of her alleged April 18, 2008, work accident, but also referenced her September 1, 2007, work accident.

The Arbitrator notes that on November 11, 2009, petitioner began treating with Dr. Lubenow, at which time her alleged April 18, 2008, work accident was not referenced and her right leg problems were attributed to her September 1, 2007, work accident.

The Arbitrator notes that from January 30, 2010, through June 7, 2010, petitioner received care from Dr. Magee at Advocate Good Shepard five times during which the April 18, 2008 work accident was not referenced and her right leg problems were attributed to her September 1, 2007, work accident four times.

The Arbitrator notes that on January 12, 2011, petitioner saw Dr. Lubenow a second time, at which time her alleged April 18, 2008, work accident was not referenced and her right leg problems were attributed to her September 1, 2007, work accident. She received care from Dr. Lubenow three mores times through August 24, 2011, during which time her alleged April 18, 2008, work accident was not referenced and her right leg problems were attributed to her September 1, 2007, work accident.

The Arbitrator notes that Dr. Lubenow first referenced petitioner's alleged April 18, 2008, work accident on August 26, 2011, (three years later) but and Dr. Lubenow later attributed his patient's right leg problems to all accidents.

Intervening occurrences?

On June 18, 2008, petitioner reported to her therapist at Co-Sport Physical Therapy that over the previous weekend she slipped and fell in the tub and fractured 4 ribs on the right side, and that she was having less pain and paresthesias in her knees prior to falling in the tub.

On October 30, 2008, petitioner was admitted to St. Joseph Hospital for alcohol abuse, drug abuse, alcoholic hepatitis, alcoholic liver disease, and a recurrent major depressive disorder. Petitioner gave a history there of "battling depression for a long time," of being placed on Paxil

for depression at age 26, of alcohol abuse for many years, of being "a recovering alcoholic," of drinking a 12-pack of beer a day for the past fifteen years, and of a two-week binge beginning on October 10, 2008, of drinking coupled with Darvocet during which time she fell and hit her head. Examination revealed bruises on her right knee.

On January 5, 2009, petitioner saw seen by Dr. Mokwe and admitted that she had heavily ingested Southern Comfort and on had slipped and fell onto her face on the floor of her kitchen.

On October 22, 2009, petitioner reported to Delnor Community Hospital that she injured her right knee while vacationing in Mexico on October 6, 2009, when she had to increase her kicking when she was caught in a current while snorkeling.

RSD symptoms pre-exist accident date

On December 22, 2009, petitioner was seen at Sherman Family Health Care where she gave a history of having suffered from chronic regional pain syndrome for the past 2.5 years, which the Arbitrator notes corresponds to an onset date of approximately June 22, 2007.

On April 2, 2011, petitioner was admitted to Sherman Hospital for alcohol abuse during which time her alleged April 18, 2008, work accident was not referenced and her right leg problems were attributed to her September 1, 2007, work accident.

On March 24, 2009, petitioner was examined by orthopedic surgeon Anuj Puppala, M.D., at the request of Respondent Blue Green Vacations. Petitioner did not mention the alleged April 18, 2008, work accident to Dr. Puppala. After examining petitioner and reviewing the medical records Dr. Puppala opined:

(1) Petitioner had bilateral lower extremity swelling;

(2) He is unsure whether a fall onto the front of both knees would cause swelling in the bilateral lower extremities and no swelling in either knee, especially 1.5 years out [i.e., from September 1, 2007] from a contusion.

On February 15, 2011, petitioner was examined by orthopedic surgeon David Trotter, M.D., at the request of Respondent Silverleaf Resorts. After examining petitioner and reviewing voluminous medical records, Dr. Trotter opined that:

(1) Petitioner's medical records do not evidence that there was any significant musculoskeletal injury on April 18, 2008;

(2) Any injuries petitioner may have sustained on April 18, 2008, resolved by April 30, 2008;

(3) There is no evidence that petitioner sustained any aggravation of a pre-existing condition on April 18, 2008;

(4) Petitioner's right lower extremity subjective complaints are not supported by the objective findings on examination;

(5) There is no current evidence of CRPS;

(6) Petitioner's current diagnoses does not have any plausible relationship to any alleged accident occurring between September 1, 2007, and April 18, 2008;

(7) Petitioner's current examination findings are most likely age-related;

(8) There is no evidence that petitioner has plausible orthopedic or musculoskeletal restrictions that would preclude her from full time work;

(9) Petitioner more likely than not have returned to work without restrictions within three months of the alleged April 18, 2008, work accident; and

(10) Petitioner is at MMI and needs no further treatment.

On November 2, 2011, petitioner was examined by orthopedic surgeon G. Klaud Miller at the request of Respondent Blue Green Vacations. After examining petitioner and reviewing the medical records, Dr. Miller opined that:

(1) There is absolutely no evidence any injury from September 1, 2007, beyond simple contusions to the knees and hands which appear to have resolved within four to six weeks;

(2) Petitioner had absolutely no evidence of any residual CRPS at the time of this examination;

(3) There is no evidence to support a diagnosis of CRPS until at least December 15, 2008, which is too far removed in time to be caused by either the September 1, 2007, work accident or the alleged April 18, 2008, work accident;

(4) Petitioner's bilateral peripheral neuropathy is not traumatic in nature and its onset is most likely idiopathic;

(5) Petitioner sustained no orthopedic injury and no knee or back injury as a result of the alleged April 18, 2008, work accident.

On February 28, 2013, petitioner was examiner by internist Dr. Liana Palacci at the request of Respondent Silverleaf Resorts. After examinimg petitioner and reviewing voluminous medical records, Dr. Palacci opined as follows:

(1) The first medical record following the alleged April 18, 2008, work accident at Midwest Sports Medicine on April 24, 2008, has no mention of her alleged right knee injury or of an aggravation of any pre-existing pain;

(2) Petitioner's finding on April 24, 2008, of no tenderness of the back despite mild low back pain and for the right knee no effusion, mild soft tissue swelling and mildly tender along the lateral inferior aspect were similar to previous treatment visits and did not change after her alleged April 18, 2008, injury;

(3) Petitioner has no significant injuries to the right knee or spine;

(4) Petitioner did not sustain any injuries on or about April 18, 2008, as she would have sought treatment right away and she would have mentioned this earlier to her treating physicians;

(5) Any injury that petitioner could have suffered on or about April 18, 2008, given the mechanism of injury would be most consistent with a soft tissue strain of the knee/spine, which is a self-limiting condition that would have already resolved;

(6) Petitioner had numerous other injuries documented in the medical records that she did not mention to Dr. Palacci;

(7) Petitioner's medical records first reference numbness and tingling in her legs on February 28, 2008, *49 days prior to her alleged April 18, 2008, work accident*, when she gave a history to Midwest Sports Medicine of a 3 week history of bilateral medial leg numbness which started after prolonged sitting, which would have begun on February 7, 2008;

(8) On June 8, 2009 at Provena-St. Joseph Hospital, petitioner admitted that her bilateral lower extremity numbness and pain dated back to at least January 2007, which was prior to petitioner's April 18, 2008, work accident;

(9) Given petitioner's history of alcohol abuse, it would not be unusual for her to develop bilateral peripheral neuropathy of the lower extremities, with periods of exacerbation in times of heavy abuse;

(10) Objective physical findings show normal range of motion of her ankle, right knee, and back with decreased sensation of right medical leg and 5th toe and some crepitus of the knees, left greater than right,

(11) Petitioner's prior diagnosis of bilateral knee arthritis is not unreasonable given her age and her physical findings of crepitus;

(12) Petitioner has bilateral peripheral neuropathy, based upon her subjective complaints, her objective sensation findings, the abnormal EMG and skin biopsy results, despite the fact that petitioner is currently symptomatic only in her right leg;

(13) Petitioner's peripheral neuropathy is more likely than not secondary to alcohol abuse and liver cirrhosis, which is a well-known and common cause of peripheral neuropathy;

(14) Alcohol abuse can also be associated with the EMG findings consistent with sensory motor peripheral neuropathy and small fiber neuropathy;

(15) A diagnosis of idiopathic neuropathy is made only if a cause cannot be identified;

(16) Dr. Miller and Dr. Everakes opined that petitioner's peripheral neuropathy was idiopathic in origin but petitioner did not tell them of her alcohol abuse;

(17) Trauma-related neuropathy is typically acute in onset with the most severe symptoms at onset, while most toxic and metabolic neuropathies occur over the course of weeks or months;

(18) Petitioner's current neuropathic symptoms have no traumatic etiology or work related cause as her first complaints of paresthesias were gradual and were noted over a year after her September 1, 2007, injury and two months before her alleged April 18, 2008, injury;

(19) There is no evidence to support a diagnosis of Complex Regional Pain Syndrome ("CRPS") as she does not currently exhibit any of the objective findings consistent with CRPS

because she has no trophic skin changes or vasomotor changes in color or temperature, and because she had a negative Quantitative Sudomotor Axon Reflex Test ("QSART") which has a high sensitivity (94%) and a high specificity (98%) for predicting CRPS;

(20) Petitioner's subjective complaints of low back and right knee pain are not supported by objective findings other than some mild tenderness to palpation of the right lateral knee joint;

(21) There are no radiographic or MRI findings that support any significant internal derangement of the right knee;

(22) Given her age and the crepitus of her knee joints found upon examination, petitioner's findings are likely consistent with underlying and pre-existing degenerative arthritis, her finding are not associated with any injuries or aggravated by any work related injuries;

(23) None of petitioner's current conditions, including her peripheral neuropathy, are casually related to her alleged April 18, 2008, work accident;

(24) Petitioner suffered no aggravation of any pre-existing condition at the alleged April 18, 2008, injury;

(25) Petitioner is at MMI with respect to her right lower extremity; and

(26) Petitioner is able to work without restrictions and she has been able to work as recently as January 2013 when she worked at trade shows.

At her May 7, 2013, deposition in this matter, Dr. Palacci stood by the opinions set forth in her February 28, 2013, report. Dr. Palacci is board certified in internal medicine (R. Ex. 1, p. 6) Dr. Palacci treats patients with peripheral neuropathy. (R. Ex. 1, p. 6) Dr. Palacci reviewed all of the medical records in this case in detail and spent 16.5 hours doing so. (R. Ex. 1, pp. 8-9, 23) Dr. Palacci testified that petitioner never developed CPRS and she had physical findings or symptoms associated with it. (R. Ex. 1, pp. 14-15) She testified that peripheral neuropathy

typically is not asymptomatic. (R. Ex. 1, pp. 16-17) Dr. Everakes diagnosed petitioner with idiopathic peripheral neuropathy. (R. Ex. 1, pp. 19-20) Dr. Palacci testified that diabetes and alcohol use are the most common causes of peripheral neuropathy, alcohol is a very common cause of peripheral neuropathy, that only possible cause of peripheral neuropathy present for petitioner was alcohol use, and that the most likely cause of her peripheral neuropathy is her alcohol use. (R. Ex. 1, pp. 20-21, 46) Dr. Palacci testified that there were no differences in symptoms or problems with her right leg that petitioner reported to her doctors on April 24, 2008, than she had reported in the visits immediately prior to the alleged April 18, 2008, work accident. (R. Ex. 1, pp. 27-28) Dr. Palacci testified that the June 8, 2009, medical records from St. Joseph Hospital establish that petitioner had bilateral lower extremity numbness and pain dating back to approximately January 2007. (R. Ex. 1, pp. 43-44) Dr. Palacci testified that Petitioner's neuropathic symptoms were not trauma related or work related as her complaints of paresthesias were gradual in onset. (R. Ex. 1, pp. 51-52) Dr. Palacci testified that the diagnoses of CRPS by Dr. Petsche and Dr. Siodlarz are consistent with alcoholic neuropathy. (R. Ex. 1, pp. 52-53) Dr. Palacci testified that petitioner's liver cirrhosis is caused by her alcoholism and that the 13 years of sobriety petitioner reported in the November 11, 2009, medical records and the "social drinking" she reported to Dr. Everakes is inconsistent with complications from liver failure because you typically need many years of alcohol use and abuse to sustain petitioner's complications from liver failure. (R. Ex. 1, pp. 87-89)

Dr. Lubenow's deposition was taken in this case on August 9, 2012. Dr. Lubenow is board certified in anesthesiology and in pain medicine. Dr. Lubenow testified that petitioner has advised him while he has been treating her petitioner has remained sober, which the Arbitrator notes is contrary to the medical evidence. Dr. Lubenow testified that both work accidents

aggravated petitioner's pre-existing latent asymptomatic idiopathic right lower extremity peripheral neuropathy, and that was a cause of her current condition. On cross-examination, Dr. Lubenow admitted that the only reference in his chart to the April 2008 work accident was in his hand-written office note of October 19, 2011, which gives no description of the mechanism of injury other than a fall onto her right knee. When asked if he had an independent recollection of what petitioner told him about the April 2008 work accident, Dr. Lubenow testified that petitioner was doing something similar to what she had been doing at the time of the September 2007 work accident. The Arbitrator notes that the mechanisms of injury for her September 1, 2007, work accident and for her alleged April 18, 2008, work accidents are significantly different as reported by petitioner, which is contrary to Dr. Lubenow's assertion regarding same. Dr. Lubenow admitted that alcohol abuse is a competent cause of peripheral neuropathy. Dr. Lubenow admitted that petitioner's August 24, 2011, fall in a church parking lot due to an uneven sidewalk that she reported to him could have exacerbated or aggravated her peripheral neuropathy. He admitted that any of the 3 falls she reported to him (a September 2007 fall, an April 2008 fall, and an August 2011 fall) could have caused or contributed to the symptoms that he treated her for. Dr. Lubenow was unable to quantify how much each of these three falls worsened her peripheral neuropathy, and he was also unable to quantify how much each of these three falls contributed to her current condition. Dr. Lubenow admitted that the only records he reviewed that were created prior to petitioner's initial November 11, 2009, with him were a prescription from Lake Cook Orthopedics, a one- page letter from Chartis authorizing petitioner's office visit with Dr. Lubenow, some records from Fox Valley Orthopedic Associates, a September 11, 2007, Doppler venus ultrasound test result, and some records from Midwest

Sports Medicine and Orthopedics. Dr. Lubenow admitted that the QSART test results ruled out the possibility that petitioner had CRPS.

The Arbitrator finds the opinions and findings of Drs. Palacci, Trotter, Miller, and Puppala to be more persuasive than those of Dr. Lubenow and of petitioner's other treating physicians. The Arbitrator adopts the findings and opinions contained in the deposition testimony of Dr. Palacci and in the reports of Drs. Palacci, Trotter, Miller, and Puppala except where they may be inconsistent with the Arbitrator's Decision herein.

The Arbitrator also finds that petitioner's testimony was not always consistent. For instance, petitioner's testified that she never abused alcohol prior to her October 30, 2008, but this is contradicted by the medical records documenting fifteen years of alcohol abuse and liver disease. Also, Petitioner's testified that she was not suffering from depression immediately prior to her September 1, 2007, but the medical records show that she has suffered from depression for many years.

II. CONCLUSIONS OF LAW

C. Did an accident occur on April 18, 2008, that arose out of and in the course of Petitioner's employment by Respondent Silverleaf Resorts?

Based upon the evidence presented at arbitration, the Arbitrator finds that the Petitioner sustained a work accident on April 18, 2008.

It is well-settled law that at hearing, it is the employee's burden to establish all of the elements of his or her claim by a preponderance of the credible evidence. *Ingalls Mem. Hospital*

v. Industrial Comm'n, 241 Ill.App.3d 710, 609 N.E.2d 775 (Ill.App. 1 Dist. 1993), including existence of causal relationship between the employment and injury. *Beattie* v. *Industrial Commission*, 276 Ill.App.3d 446, 657 N.E.2d 1196 (1995). An employer's liability for benefits cannot be based on guess, speculation or conjecture. *Illinois Bell Telephone* v. *Industrial Commission*, 265 Ill.App.3d 681, 638 N.E.2d 207 (1994).

It is true that Petitioner's accident was unwitnessed and she continued working until August 27, 2009, eighteen months later. On the other hand, she reported the occurrence on April 21, 2008, three days later.

It is also true that Petitioner did not seek medical attention for six days and failed to mention the new accident to her first doctor. Petitioner's symptoms were essentially the same as before and no new work restrictions were imposed. Yet, on April 28, 2008, the petitioner gave an "aggravation history" to Fox Valley Orthopedics. Later histories consistently point to the earlier occurrence with a different employer.

Nevertheless, the petitioner's testimony about the occurrence was credible, she gave notice shortly afterwards and also notified a treating doctor shortly after the accident. As a result, the Petitioner proved, more likely than not, that an accident occurred while working for Silverleaf.

F. Is the Petitioner's current condition of ill being causally related to the alleged April 18, 2008, work injury?

Despite finding in favor of the Petitioner on the issue of accident, the Arbitrator finds that the Petitioner failed to prove that her current condition is casually related to the occurrence.

The Arbitrator finds that petitioner sustained no permanent injury or permanent aggravation, exacerbation, or acceleration of her right lower extremity condition or her depression as a result of the April 18, 2008, work accident. The Arbitrator finds that, at most, petitioner sustained a strain/sprain of her right knee on April 18, 2008, that resolved by April 30, 2008, at the earliest and at the latest by September 7, 2008, when she was returned to work full duty by her treating orthopedic surgeon.

Petitioner continued working on April 18, 2008, after her work accident of that day and first missed time from work on August 27, 2009, 18 months later.

Petitioner first sought treatment on April 24, 2008, six days later, and she did not mention the work accident at that time. Petitioner's symptoms reported to her doctors relating to her right leg and knee were essentially the same as the symptoms she reported seven weeks earlier on February 28, 2008. No new work restrictions were imposed by her doctors.

The Arbitrator agrees with Dr. Palacci that petitioner's peripheral neuropathy was not caused by any work trauma and was most likely caused by petitioner's chronic alcohol abuse. Petitioner testified that her peripheral neuropathy symptoms pre-existed the April 18, 2008, work accident. The Arbitrator further finds that petitioner's peripheral neuropathy preceded the April 18, 2008, work accident and was not caused, exacerbated or accelerated by the April 18, 2008, work accident.

On December 22, 2009, petitioner reported to her doctors that she had complex regional pain syndrome for the past 2.5 years, or since about January 2007. The Arbitrator agrees with Dr. Palacci that petitioner never developed actual complex regional pain syndrome. Petitioner admitted that all of her complex regional pain syndrome symptoms pre-existed the April 18, 2008, work accident. The Arbitrator further finds that even if petitioner did in fact develop

complex regional pain syndrome it developed occurred eighteen months prior to her April 18, 2008, work injury and it was not aggravated by the same.

Petitioner admitted that her depression pre-existed her April 18, 2008, work accident. The Arbitrator finds that petitioner's depression was not caused, aggravated, accelerated or exacerbated by the April 18, 2008, work accident.

Dr. Trotter opined that petitioner's medical records do not evidence that there was any significant musculoskeletal injury on April 18, 2008, that any injuries petitioner may have sustained on April 18, 2008, resolved by April 30, 2008, and that there is no evidence that petitioner sustained any aggravation of a pre-existing condition on April 18, 2008.

Dr. Miller opined that petitioner sustained no orthopedic injury and no knee or back injury as a result of the April 18, 2008, work accident.

Dr. Palacci opined that petitioner sustained no knee injury as a result of the April 18, 2008, work accident.

The Arbitrator finds Dr. Lubenow's opinion unpersuasive that petitioner aggravated her pre-existing peripheral neuropathy while working on April 18, 2008 for the following three reasons. First, Dr. Lubenow reviewed no contemporaneous records regarding the alleged April 18, 2008, work accident. Second, he did not know the mechanism of injury. Finally, he incorrectly believed that petitioner was engaged in the same activity for both work injuries.

In summary, the Petitioner failed to prove that her current right knee condition was caused by the accident on April 18, 2008.

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

medical services? Is petitioner's medical treatment causally related to the alleged April 18, 2008, work accident?

The Arbitrator finds that the Petitioner did not meet her burden or proving by a preponderance of the credible evidence that any of the submitted medical bills were for treatment that was causally related to the April 18, 2008, work accident.

At that time of the April 18, 2008, accident petitioner was still treating for injuries to her right leg resulting from her September 1, 2007, work accident. The Arbitrator finds that petitioner sustained no permanent injury or permanent aggravation, exacerbation, or acceleration of her right lower extremity condition or her depression as a result of the April 18, 2008, work accident. The Arbitrator finds that, at most, petitioner sustained a strain/sprain of her right knee on April 18, 2008, that resolved by April 30, 2008, at the earliest and at the latest by September 7, 2008, when she was returned to work full duty by her treating orthopedic surgeon.

Petitioner continued working until August 27, 2009, eighteen months later. Petitioner first sought treatment after her April 18, 2008, work accident on April 24, 2008, six days later, but did not mention the April 18, 2008, work accident at that time. Petitioner's symptoms reported to her doctors relating to her right leg and knee were essentially the same as the symptoms she reported seven weeks earlier on February 28, 2008. No new work restrictions were imposed by her doctors as a result of the alleged April 18, 2008, work accident.

The Arbitrator further finds that petitioner has proved that the treatment she received from April 24, 2008, through September 7, 2008, was causally related to injuries she received on April 18, 2008.

K. Is petitioner entitled to any prospective medical care?

Based upon the findings above, no prospective medical care is awarded.

L. Is petitioner entitled to any TTD benefits?

Based upon the findings above and noting that the petitioner did not miss work until August 27, 2009, the Arbitrator awards no temporary total disability benefits.

M. Should penalties or fees be imposed on Respondent?

No penalties or fees are awarded in this case.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Deborah Sands,

Petitioner,

vs.

NO: 09 WC 09984

15IWCC0069

Blue Green Vacations Unlimited, Inc.,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 29, 2013, is hereby affirmed and adopted.

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

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

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

No bond is required for 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: JAN 2 7 2015
SM/sk
o-1/15/2015
44

Stephen J. Mathis

Mario Basurto

David L. Gore

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

SANDS, DEBORAH
Employee/Petitioner

Case# **09WC009984**

10WC013465

BLUE GREEN VACATIONS
Employer/Respondent

15IWCC0069

On 8/29/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.06% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0365 BRIAN J McMANUS & ASSOC LTD
MARK CONNOLLY
30 N LASALLE ST SUITE 2126
CHICAGO, IL 60602

1454 THOMAS & ASSOCIATES
MICHAEL PILLER
300 S RIVERSIDE PLZ SUITE 2330
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

15IWCC0069

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Deborah Sands,
Employee/Petitioner

v.

Blue Green Vacations,
Employer/Respondent

Case # 09 WC 009984

Consolidated cases: 10 WC 13465

An *Application for Adjustment 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 **05-29-13**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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, **09-01-07**, 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 $**39,370.76**; the average weekly wage was $**757.13**.

On the date of accident, Petitioner was **46** years of age, ***single*** with **0** dependent children.

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

Respondent shall be given a credit of $**1,802.73** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**0.00** for other benefits, for a total credit of $**1,802.73**.

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

ORDER

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $ **504.75**/week for **3-4/7** weeks, commencing **09-11-07** through **10-05-07**, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from **09-01-07** through**10-05-17**, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall be given a credit of $**1,802.93** for temporary total disability benefits that have been paid.

Medical benefits

Respondent shall pay $**0.00** in reasonable and necessary medical services as provided in Section 8(a) of the Act, as all reasonable and necessary medical has been paid.

Penalties

Respondent shall pay to Petitioner **NO** penalties as provided in Sections 16, 19(k) or 19(l) 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

07-19-13
Date

ICArbDec19(b)

AUG 2 9 2013

FINDINGS OF FACT:

Petitioner, Deborah Sands, testified that on 9/1/07, while working part-time for Blue Green Vacations at an outdoor trade show, her foot became tangled in a tablecloth causing her to fall onto the pavement landing on both knees and palms. She received onsite first aid for her bleeding knees and had gravel removed from her palms. Petitioner did not seek or receive other medical attention that day.

On 9/7/07, Petitioner saw Dr. David Anderson. He diagnosed bilateral knee and hand contusions, and ordered an MRI for a suspected right knee tibial plateau fracture (Px-1). Petitioner testified Dr. Anderson took her completely off work that day, though Dr. Anderson's records do not show this (Px-1). A 9/13/07 right knee MRI showed no fractures, no bone marrow edema and only minimal effusion (Rx-11).

Petitioner testified the pain in her hands had resolved by 10/5/07. Her left knee healed after a month or two. Dr. Anderson released her to restricted work on 10/5/07. Those restrictions were: no excessive twisting, turning, bending sitting, standing or walking for more than 30 minutes, "sitting okay." (Px-1, 10/5/07 Work Restriction Sheet).

Petitioner testified that around 10/5/07, she noticed tingling in her right leg. However, Dr. Anderson did not note any such complaint or symptom on 10/5/07 (Px-1). Rather, his note of that date states, "Deborah is doing better ... she is complaining of off and on right knee pain as well as left medial knee pain, but, again, things are improving. Her hands are doing pretty well." (Px-1, 10/5/07 History). Petitioner testified she never told Dr. Anderson her right knee pain was only "on and off."

On 10/26/07, Petitioner continued with physical therapy prescribed by Dr. Anderson, who advised her to return to see him in 3-4 weeks. Dr. Anderson did not record any complaints of back pain or numbness to either leg on 10/26/07 (Px-1).

Petitioner admitted that she chose not to go follow Dr. Anderson's instructions to see him in November of 2007. She likewise did not return to see him in December 2007, January 2008 or February 2008, until 2/28/08 (Px-1).

In November 2007, Petitioner voluntarily changed jobs, leaving her part-time job at Blue Green Vacations to do similar part-time work for Silverleaf Resorts. She testified on direct examination that she had numbness in her right leg at that time, but admitted she did not return to Dr. Anderson with this complaint.

When Petitioner did return to see Dr. Anderson on 2/28/08, after a four month break in his treatment, his records noted for the first time her complaint of numbness in both legs, which she told him had begun about three weeks before, after she had been doing a lot of prolonged standing (Px-1, 2/28/08). At this time, the Petitioner was no longer working for Blue Green Vacations.

Dr. Anderson's records show that on 2/28/08, Petitioner denied any back pain. The first mention of back pain in any records entered into evidence is in the records of Midwest Sports Medicine & Orthopedics, at her 4/24/08 visit (Px-1a).

Petitioner testified that on 4/18/08 she sustained a second work-related accident while working for a different employer, Silverleaf Resorts. She testified that on 4/18/08 she was lifting a prize wheel onto a table when she twisted her right knee and hurt her low back. She felt a sharp pain at that time. (The Arbitrator's findings and Award regarding Petitioner's 4/18/08 alleged accident is in the companion claim number 10 WC 13465).

Petitioner's first treatment following the 4/18/08 incident was with Dr. O'Dell at Midwest Orthopedics on 4/24/08. Those records show she then complained of bilateral leg numbness, right knee pain and mild low back pain (Px-1a).

Dr. Timothy Petsche's 5/9/08 note reported a recent right knee aggravation on 4/18/08 "while lifting and twisting" (Px-3a, 5/9/08). Dr. Petsche's assessment was: bilateral knee contusions

anteriorly with residual symptoms, exacerbation of right knee pain with recent twisting injury and bilateral lower extremity paresthesia, cannot exclude lumbar spine pathology (Px-3a, 5/9/08).

On 5/20/08, Dr. Petsche's notes reported the date of injury to be 9/1/07, but also noted that the patient recently reinjured her legs with a recent fall on 5/2/08 when lifting a wheel onto a table at work. She did not fall; she just felt a sharp twinge in her legs. She noticed both knees had swelled after that again (Px-3a, 5/20/08). On 6/19/08, Dr. Petsche released Petitioner to return to work with restrictions which then also included no lifting over 20 lbs (Px-3a, 5/20/08). Petitioner testified she did return to work at Silverleaf Resorts until she was laid off.

On 9/9/08, Dr. Petsche released Petitioner to full-duty work without restriction (Px-3a, 9/9/08). Following treatment and work restrictions later that month for some swelling in her right foot, Dr. Petsche wrote another full-duty return to work slip on 12/15/08 (Px-3a, 12/15/08).

Petitioner testified that since her 9/1/07 accident, she has gone bike riding, hiking and snorkeling in the ocean. She admitted that while snorkeling in October 2009, she got caught in a current and that the increased kicking she did then increased and aggravated her right leg pain. She thought she told Dr. Lubenow about this incident the next time she saw him, though his records do not report she told him this (Px-4a).

Petitioner testified she fell again onto her hands and right knee on 8/14/11. She required emergency room treatment for this injury. Petitioner admitted this "definitely aggravated" her right knee all over again.

Petitioner admitted that "Workman's Comp" was paying her bills for a period of time after her 9/1/07 injury. Respondent offered into evidence a printout showing all of the medical bills paid by Respondent through the date of the Arbitration hearing (Rx-12).

Other than her current part-time job at Crossmark (Sam's Club), Petitioner was asked about her other job since leaving Silverleaf Resorts. She mentioned a one week job at a call center and a hostess job that lasted for three days. When asked about her other jobs, she answered, "I believe that's the

only two I've tried." However, when asked on cross-examination whether she ever worked in Lake Geneva, WI, Petitioner then remembered she had worked for a company, "Synergy" the summer of 2012, from June until September. Her job at Crossmark started the following month.

Petitioner currently has a valid driver's license and drives a car. She testified that Dr. Lubenow restricted her driving to only 30 minutes at a time, though Dr. Lubenow's records do not note any restrictions of her driving (Px-4a).

Petitioner told Dr. Lubenow her right lower extremity pain began with her 9/1/07 fall (Px-4a, 1/17/12 report). Based in part on Petitioner's history, Dr. Lubenow gave his opinion that Petitioner had a pre-existing peripheral neuropathy which was latent and asymptomatic until her 2007 fall (Px-4a, 1/17/12 report).

Prior to 10/30/08, Petitioner denied any problems with alcohol abuse and claimed to be only a social drinker. Petitioner testified the first time in her life that she had any problems with alcohol abuse was at the time of her admission to St. Joseph Provena Hospital on 10/30/08. That was when she testified she was diagnosed with cirrhosis of the liver.

Petitioner admitted that she required treatment for substance abuse (marijuana) when she was 21, but denied use since then, testifying that she has remained, "sober, clean, absolutely fine." Petitioner did not recall telling Dr. Anderson on 9/7/07 that alcohol was one of her "habits," and she did not know why he might put that in his report (Px-1).

The records in evidence conflict with Petitioner's testimony and recollection. Dr. Anderson did note Petitioner's prior history of alcohol use when he saw Petitioner on 9/7/07, noting that alcohol was, in fact, one of her habits (Rx-1, 9/7/07 visit).

At her 10/30/08 admission to St. Joseph Hospital, Petitioner told personnel there that she was a "recovering alcoholic," (Rx-9, 10/30/08 History and Physical). During that hospital admission, she also reported to Dr. Mokwe that she drank a 12-pack of beer a day for 15 years (Rx-9, 10/30/08 Mokwe report, p.2). The Psychiatric Evaluation of Syad Anwar, MD, dated 11/5/08 noted, "The

patient did state that she had a problem with alcohol, has had a problem with alcohol for many years. She states she was in rehab one time before in the program Hope in the Elgin area. That was many years ago. She has used marijuana for a long period of time but has not done any for the last 5 years." (Rx-9, 11/5/08 Psychiatric Evaluation, p.1),

Petitioner did not recall telling any doctors she ever drank ½ gallon of vodka per day, nor did she recall ever drinking that much alcohol. However, records of Sherman Hospital where Petitioner was admitted in April 2011, report she gave a history of ingesting vodka, "half a gallon twice a day." (Rx-10, 4/3/11 History and Physical).

Following her 10/30/08 admission for binge drinking at St. Joseph Hospital, Petitioner was discharged in November 2008, and testified she did not touch a drop of alcohol until one month before her next hospitalization, which she thought was in April 2009. This is contradicted by Dr. Mokwe's records, which show that on 1/5/09, Petitioner reported she "relapsed" and "ingested 'Southern Comfort' heavily." (Rx-8, 1/5/09). Dr. Mokwe noted that Petitioner slipped in her kitchen on 1/3/09, fell down and sustained contusion of her face, and bled from her nostrils (Rx-8, 1/5/09).

The Petitioner underwent five Section 12 examinations at the request of both Blue Green and Silverleaf Resorts.

The first was on 3/3/09, when the Petitioner was examined by Dr. Anuj Puppala. She apparently did not tell Dr. Puppala about her drinking problems or history as he stated her social history "is not significant for ... drinking." (Rx-6, p. 2). Dr. Puppala noted, after reviewing records, that the first report of numbness and swelling in Petitioner's legs did not develop until February 2008. His diagnosis was "bilateral lower extremity swelling," 1½ years following a knee contusion (Rx-6, p. 5). Dr. Puppala was unsure whether Petitioner's fall onto her knees would be the cause of this leg swelling, when there was no swelling in either knee. He found Petitioner able to work full duty from an orthopedic standpoint (Rx-6, p. 7).

On 4/13/09, cardiologist, Bruce Bergelson, M.D., saw Petitioner for a Section 12 examination. He noted she described only intermittent swelling in her legs which did not develop until months after her 9/07 fall. Petitioner reported that swelling in her legs increased after a reinjury to her legs on 5/2/08. At his examination, he found her lower extremities to be without edema. He attributed her intermittent leg swelling to most likely be related to local injury at her knees, but not specifically the 9/1/07 injury, and he noted, "This injury has largely resolved." (Rx-7, p. 2).

On 2/15/11, Petitioner was seen by Dr. David Trotter, M.D., for a Section 12 examination. Dr. Trotter's report of that date indicates he also reviewed voluminous treating records of Petitioner's treatment (Rx-4). Petitioner gave Dr. Trotter histories of both her 9/1/07 Blue Green accident, claiming she broke her knee cap, as well as the alleged 4/18/08 Silverleaf work injury in which she claimed she twisted her right knee and felt sudden back pain, after moving a 30-40 pound prize wheel (Rx-4, p. 1). Dr. Trotter reviewed Petitioner's right knee 9/13/07 MRI report, noting it was "unremarkable," as well as reviewing the actual film which revealed no fractures (Rx-4, pp. 3, 5). Though Petitioner also reported to Dr. Trotter that she had been diagnosed with CRPS, he did not believe she had CRPS because Petitioner "had no particular hypersensitivity of either lower extremity, no abnormal shininess or sweating, no significant temperature changes, color changes or hair growth, assymetry of one leg versus the other (Rx-4, pp. 2, 4). Dr. Trotter gave his opinion that, with regard to Petitioner's 9/1/07 injury, she appeared "to have exclusively sustained bilateral knee contusions and contusions at the hands, without evidence of internal derangement type injuries." (Rx-4, p. 4). Dr. Trotter's diagnosis was: resolved contusions of the hands and knees, with no evidence of Complex Regional Pain Syndrome. He believed her current findings to be more likely than not related to age or non-age-related degenerative disease, but found no evidence that there was any causation or aggravation of her conditions to either the 9/1/07 or 4/18/08 accident dates (Rx-4, p. 4).

Finally, Dr. Trotter opined that Petitioner more likely than not could have returned to "full-time workplace activities without restrictions," within approximately three months of her dates of injuries (Rx-4, p. 5).

On 11/2/11, Petitioner was seen for a Section 12 examination with Dr. G. Klaud Miller, M.D. Dr. Miller also reviewed treating records of Petitioner, noting that they documented six separate fall down injuries: (1) The subject occurrence of 9/1/07; (2) the alleged 4/18/08 alleged claim when she was injured while lifting and twisting a prize wheel; (3) a 5/2/08 lifting injury after which Petitioner noted increased swelling in her legs; (4) a 6/15/08 slip in a tub resulting in rib fractures; (5) a 7/28/10 injury in which she bent over and felt the acute onset in her back, and (6) an 8/14 or 8/19 fall onto her hands and knees in church (Rx-5, pp. 1, 2, 8). Dr. Miller noted the history of injuries is critical.

Regarding the 9/1/07 injury which is the subject of this claim, Dr. Miller noted Dr. Anderson's 10/5/07 examination of Petitioner's right knee was completely normal, and that Dr. Anderson released her with restrictions on that date. (Rx-5, p. 4). Dr. Miller noted the "four month gap in treatment until 2/28/08," at which date Petitioner gave a "three week history of bilateral medial leg numbness," and that Petitioner "specifically denied any low back pain." (Rx-5, p. 4).

Dr. Miller reviewed the actual right knee MRI film of 9/13/08 and agreed with the radiologist who read it as, "completely normal, except for mild effusion." There was specifically no evidence of any fracture." (Rx-5, p. 10). Dr. Miller noted that Petitioner's statement to Dr. Trotter on 2/15/11, that she fractured her kneecap and was casted, was "obviously not consistent with the other records," (Rx-5, p. 12).

Dr. Miller took a history from Petitioner, who related the work injuries of 9/1/07 and 4/12/08, but with no mention of her other four accidents (Rx-5, p. 13). Petitioner told Dr. Miller that her spine pain and gluteal pains were related to the September 1, 2007 incident (Rx-5, p. 13). Dr. Miller noted that "there were severe pain behaviors throughout the entire examination." (Rx-5, p. 15).

Dr. Miller gave his opinion that "there is absolutely no evidence of any injury from September 1, 2007, beyond simple contusions to the knees and hands." (Rx-5, p. 15). Dr. Miller observed that the first evidence that could be construed as CRPS was documented by Dr. Petsche on 12/15/08, some 15 months after the 9/1/07 accident. Dr. Miller noted this was also more than five months after the 4/18/08 injury and it was "too far divorced" to be related to either (Rx-5, p. 15).

Dr. Miller noted Petitioner's records document bilateral peripheral neuropathy, but stated most such peripheral neuropathies are not traumatic in nature, and he opined that Petitioner's peripheral neuropathy was not related to the 9/1/07 incident (Rx-5, pp. 15, 16). Dr. Miller's report did not document Petitioner's history of alcohol abuse.

The only treatment that Dr. Miller found to be related to the 9/1/07 incident was Dr. Anderson's treatment between 9/7/07 and 10/26/07. (Rx-5, p. 16).

Petitioner was seen by Dr. Liana Palacci for a Section 12 examination on 2/28/13. Dr. Palacci is Board-Certified in Internal Medicine and teaches at St. Joseph Hospital. She treats patients with peripheral neuropathy, among other conditions.

Dr. Palacci spent 16½ hours examining Petitioner and reviewing voluminous records and a summary of Dr. Lubenow's deposition sent by Respondent's counsel (Rx-1, pp. 8, 9, 23). She gave her evidence deposition on 5/7/13 (Rx-1).

Dr. Palacci did not believe Petitioner ever developed complex regional pain syndrome (CRPS) up to the date of her exam (Rx-1, p. 14). Petitioner did not exhibit the usual signs associated with that condition such as: abnormal skin changes, abnormal changes in skin temperature, sweating of the skin, nail findings or symptoms including burning, chronic pain and aching (Rx-1, p. 15).

Dr. Palacci testified that peripheral neuropathy is not typically asymptomatic, and in Petitioner's case, Petitioner would not have developed peripheral neuropathy as a result of her injury (Rx-1, pp. 16-18). The most common causes of peripheral neuropathy are diabetes and alcohol use; the Petitioner did not have diabetes (Rx-1, p. 20). Trauma related neuropathy is typically acute in

onset, with the most severe symptoms occurring at onset (Rx-1, p. 51). If Petitioner's peripheral neuropathy symptoms were traumatic in origin, they would have started within one week or so of her trauma, not five months later (Rx-1, p. 59). Petitioner's neuropathy symptoms were not trauma-related or work related because her paresthesias was gradual in onset (Rx-1, p. 51).

During her examination, Petitioner told Dr. Palacci about the 9/1/07 and 4/18/08 work injuries, stating she attributed her right knee pain and right ankle swelling to her injuries of September 1st and the numbness and tingling of the right lower extremity to the April 18th injury (Rx-1, p. 26). Petitioner denied any other traumatic events or injuries (Rx-1, p. 27).

Petitioner told Dr. Palacci that when she was 28 years old, she was treated for three months with Paxil, an anti-depressant, when her mother passed away (Rx-1, p. 31). Petitioner admitted she was treated for depression again in October of 2007, after she had a suicide attempt (Rx-1, p. 31).

Petitioner told Dr. Palacci that before September 2007, she only drank alcohol socially. She stated that after that date, she started drinking a six pack of beer per day (Rx-1, p. 32). Petitioner denied to Dr. Palacci any alcohol consumption since January 2010, and also denied ever attending any AA meetings or alcohol rehabilitation (Rx-1, p. 32).

Dr. Palacci noted, from her review of the records, Petitioner's significant past history of alcoholism, which resulted of which Petitioner developing multiple complications, including liver cirrhosis, splenomegaly and thrombocytopenia (Rx-1, p. 38). The treating records documented several injuries which Petitioner did not report to her, including an 8/24/11 fall at a church, the 10/22/09 snorkeling injury which caused right knee and ankle pain, a 7/21/10 injury in which Petitioner picked up something and felt pain in her lower left back, Dr. Mokwe's 10/30/08 note about a fall following drinking with bruising of the right knee and lower back, and a 6/18/08 slip and fall in a tub, causing fractures to four ribs and increase in knee pain and paresthesias (Rx-1, pp. 42, 43). Dr. Palacci opined that more likely than not, Petitioner's history of alcohol use is the cause of her peripheral neuropathy

(Rx-1, p. 46). Peripheral neuropathy is not caused by either mechanism of injury which Petitioner described for her 9/1/07 or 4/18/08 accidents (Rx-1, p. 47).

Dr. Palacci testified that neither Drs. Anderson nor Lubenow referred in their records to Petitioner's history of alcohol abuse or her hospitalizations for liver complications (Rx-1, p. 47). Petitioner's current right knee pain is most likely caused by her arthritis (Rx-1, p. 48). That arthritis was not caused or aggravated by either the 9/1/07 or 4/18/08 injury (Rx-1, p. 48). Petitioner's lower extremity numbness, tingling and paresthesias were a result of her neuropathy secondary to alcohol abuse (Rx-1, p. 49).

Petitioner admitted she researched the diagnoses of her doctors including the causes of orthopedic injuries. She researched diagnoses of cirrhosis of the liver, causes of peripheral neuropathy and CRPS.

CONCLUSIONS OF LAW:

IN SUPPORT OF THE ARBITRATOR'S FINDINGS RELATING TO "F," IS THE PETITIONER'S PRESENT CONDITION OF ILL BEING CAUSALLY RELATED TO THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

The records show Petitioner sustained contusions to her palms and knees following her 9/1/07 work accident. Dr. Anderson was Petitioner's initial primary physician for these injuries, and in fact, was the only doctor whom Petitioner saw prior to 4/18/08. He released the Petitioner to restricted duty on 10/5/07, noting then that most of her symptoms were resolved. On 10/26/07, he advised her to finish physical therapy and return to see him in three to four weeks (Px-1).

Petitioner abandoned Dr. Anderson's treatment by not returning to see him in November 2007; this was her own decision. The restrictions placed by Dr. Anderson in September and October 2007 cannot be considered "permanent" as Petitioner chose to stop treating with Dr. Anderson after her 10/26/07 visit with him. Petitioner returned to see Dr. Anderson on 2/28/08, almost six months after

the 9/1/07 accident, only when she developed, 3 weeks earlier, a new symptom of numbness in her right leg. The Arbitrator finds this new symptom to not be related to Petitioner's 9/1/07 accident. In so finding, the Arbitrator adopts the opinions of Drs. Anderson, Trotter, Puppala, Miller, Bergelson and Palacci.

The Arbitrator does not find the opinion of Dr. Lubenow to be credible, as Petitioner did not provide him with a complete or accurate history regarding her alcohol abuse and her other falls. It is clear that Petitioner was not forthright in telling Dr. Lubenow, as well as other doctors she saw, the extent of her past alcohol abuse. Further, Petitioner was not accurate in telling Dr. Lubenow and other doctors who examined her that her leg numbness began as a result of her 9/1/07 accident. The Arbitrator finds no mention of leg numbness in any medical records prior to Dr. Anderson's 2/28/08 note (Px-1).

The Arbitrator does not find Petitioner to be a credible historian. Her testimony is contradicted on numerous occasions by her own doctor's medical records. She testified she never abused alcohol before her 9/1/07 accident, and that the first time she did was shortly before her 10/30/08 hospitalization at St. Joseph Hospital following a drinking binge. She testified and told her doctors that prior to 9/1/07, she only drank socially. She told Dr. Palacci at her 2/28/13 examination that she never attended AA meetings or was in alcohol rehabilitation, and that she had not consumed alcohol since January 2010. She denied other traumatic injuries. She did not know how or why Dr. Anderson came to note in his chart on 9/7/07, that alcohol was one of her activities.

Petitioner's treating records tell another story. The history and physical of her 10/30/08 admission to St. Joseph Hospital (Rx-9) notes Petitioner's admission that she is a "recovering alcoholic." It notes she drank a 12 pack of beer a day for the past 15 years (Rx-9, Mokwe Consultation Report, p. 2). The records note that "when she returned to her dad's about 7-8 years ago, she went to AA in STC..." (Rx-9).

Petitioner told Dr. Palacci that the numbness and tingling in her right lower extremity did not begin until after the April 18th injury (Rx-1, p. 26). As Dr. Palacci noted, Petitioner's hospital records from St. Joseph's 10/30/08 admission documented Petitioner's past binge drinking, but also her long history of alcohol abuse in which Petitioner drank heavily for the past 15 years (Rx-1, p. 45-46). St. Joseph's records show Petitioner admitted to consuming a 12 pack of beer to a half gallon of vodka, twice daily (Rx-9).

Petitioner claims she told Dr. Lubenow in November 2011 about her snorkeling accident, though his records do not record this in his records.

When asked about the jobs she has worked since leaving Silverleaf Resorts, Petitioner initially omitted discussing her job at Synergy, where she worked from June 2012 to September 2012. Only when specifically asked about that job in Lake Geneva, a job that lasted 3 months, did she recall it and provide details about it.

Petitioner testified Dr. Lubenow restricted her driving a car to 30 minutes at a time. However, Dr. Lubenow's records contain no such restriction (Px-4a).

Petitioner testified that her toes were tingly and she had muscle spasms from her right ankle to the right side of her knee since 9/1/07. However, Dr. Anderson's records (Rx-1) do not report this.

Petitioner testified that following her release from St. Joseph Hospital in November of 2008, she did not touch a drop of alcohol until shortly before an April 2009 hospitalization. However, this is contracted by Dr. Mokwe's 1/5/09 office note in which he reported that Petitioner had been consuming "Southern Comfort" quite heavily prior to that date, and in fact had fallen down at home two days before that (Rx-8).

When asked by Dr. Palacci about any other injuries, the Petitioner only mentioned the 9/1/07 and 4/18/08 work injuries; she did not describe the other fall downs.

The Arbitrator finds that the Petitioner has not met her burden of proving that any condition of ill-being, other than contusions to both knees and hands, were causally related to her employment at Respondent, Blue Green.

IN SUPPORT OF THE ARBITRATOR'S FINDINGS RELATIVE TO "J," WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY, AND HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner admitted Respondent provided the medical care following her 9/1/07 accident. Petitioner chose to terminate treatment and did not return to see Dr. Anderson in November of 2007, as he had recommended. Petitioner never gave an explanation for this.

When Petitioner finally returned to see Dr. Anderson on 2/28/08, it was for a new symptom which developed three weeks earlier, after she had been standing on her feet for a prolonged period of time.

The Arbitrator finds that all of the treatment Petitioner received from 9/1/07 through 10/26/07 was reasonable and necessary, and that it was paid for by Respondent. The Arbitrator finds the numbness in Petitioner's right leg which developed in February 2008 to be a new, unrelated symptom which was not caused, aggravated or exacerbated by the 9/1/07 work injury. The Arbitrator finds that all treatment Petitioner received on and after 2/28/08 was not causally related to her 9/1/07 work accident. At the time her new symptom developed in February 2008, Petitioner was not even working for Respondent, Blue Green Vacations.

For the reasons stated above, the Arbitrator finds that Petitioner has not met her burden of proving she is entitled to any further medical benefits, related to this claim, and that Respondent has paid all appropriate charges for all reasonable and necessary medical services.

IN SUPPORT OF THE ARBITRATOR'S FINDINGS RELATING TO "K," IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator adopts the opinions and conclusions of the Respondent Section 12 experts, who opined that the Petitioner had recovered from her 9/1/07 contusions, bruises and abrasions within a few months following that injury. For those reasons, the Arbitrator finds that the Petitioner is not entitled to any prospective medical care from Respondent, as a result of the 9/1/07 work injury.

IN SUPPORT OF THE ARBITRATOR'S FINDINGS RELATING TO "L" WHAT TEMPORARY TOTAL DISABILITY BENEFITS ARE IN DISPUTE, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner was authorized off work by Dr. Anderson from 9/7/07, until he released her to light-duty restrictions on 10/5/07. Petitioner admitted that her employer, Blue Green, was able to accommodate Dr. Anderson's restrictions, beginning 10/6/07.

In November 2007, Petitioner found new employment with Siverleaf Resorts. She continued working there until she was taken off of work for medical reasons not related to her 9/1/07 accident.

The Arbitrator finds that Petitioner is entitled to temporary total disability benefits from 9/7/07-10/5/07 (4-1/7 weeks). The Arbitrator finds that Petitioner has not met her burden of proving she is entitled to any TTD benefits relating to this claim, after 10/5/07, as Respondent Blue Green was able to begin accommodating her restrictions, and Petitioner returned to work for them beginning 10/6/07.

IN SUPPORT OF THE ARBITRATOR'S FINDINGS RELATING TO "M,' SHOULD ANY FEES OR PENALTIES BE IMPOSED UPON THE RESPONDENT, THE ARBITRATOR FINDS AS FOLLOWS:

Respondent, Blue Green, authorized and paid for Petitioner's medical benefits and TTD through her return to work on 10/6/07. The Arbitrator finds that Respondent continued to pay

Petitioner's medical benefits after 10/5/07, including treatment at Mid West Sports Medicine & Orthopedics, Fox Valley Orthopedic Associates and Co-Sport Physical Therapy, well into 2008.

Respondent's refusal to authorize medical treatment and pay TTD benefits beyond what it has paid (Rx-12) was based upon medical evidence showing that Petitioner's condition of ill-being and lost time after 2/28/08 were not causally related to her 9/1/07 injuries, which had resolved prior to that date.

For the reasons stated above, the Arbitrator finds that Petitioner has not met her burden of proving she is entitled to any fees or penalties from Respondent.

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

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

vs. No. 11 INC 00048

Thomas D. Broomfield, Individually and as President of
Precision Metalize (a dissolved corporation),
Respondent.

15IWCC0070

DECISION AND OPINION REGARDING INSURANCE COMPLIANCE

Petitioner, the Illinois Workers' Compensation Commission, Insurance Compliance Division, brings this action, by and through the office of the Illinois Attorney General, against the above-captioned Respondent, alleging violation of Section 4(a) of the Illinois Workers' Compensation Act. Proper and timely notice was provided to Respondent and a hearing was held before Commissioner Donohoo in Collinsville, Illinois on February 18, 2014. Respondent Thomas Broomfield, individually, and on behalf of Precision Metalize, appeared by counsel.

Petitioner alleged that Respondent knowingly and willfully lacked workers' compensation insurance coverage from November 16, 2008, to June 1, 2010, the date the business dissolved. Prior to hearing, the parties stipulated to a 562 day period of non-insurance.

Herbert Boker, an employee of Respondent, alleged that he was injured in a work-related accident on December 7, 2009, during Respondent's uninsured period. Boker's claim was filed with the Illinois Workers' Compensation Commission, and the Injured Workers' Benefit Fund was named as a Respondent in Case No. 10 WC 25510. On February 16, 2011, the Commission found the employee's claim compensable, and the Fund eventually paid the worker a total of $36,147.85.

In its non-compliance case against Respondent, the Commission sought the maximum fine allowed under the Act, $500.00 per day for each day Mr. Broomfield did business as Precision Metalize and failed to provide coverage for his employees (562 days X $500.00 = $281,000.00), plus the amount of the premium, as prescribed by the Act for the period during which he lacked insurance (562 days X $98.56 = $52,198.56) for a total of $327,198.56. PX4. The statutory minimum fine is $10,000.00, pursuant to Section 4(d) of the Act.

At the time of hearing, Precision Metalize had dissolved, and Respondent Broomfield's debts had been discharged in bankruptcy proceedings. Therefore, the Commission did not seek refund of the amount that the Fund had paid Respondent's injured worker, as that debt had been discharged in bankruptcy. However, debts for fines and penalties are not discharged.

After considering the entire record, the Commission finds that Respondent knowingly and willfully violated Section 4(d) of the Act and Section 7100.100 of the Rules Governing Practice before the Illinois Workers' Compensation Commission from November 16, 2008 through June 1, 2010. The Commission finds that, as a result of Respondent's non-compliance, he shall be held liable and pay a fine of $62,198.56, pursuant to Section 4(d) of the Act and Section 7100.100(b)(1)(2) of the Rules for the reasons set forth below:

FINDINGS OF FACT AND CONCLUSIONS OF LAW

1. Petitioner presented Joseph Stumph, an investigator for the Insurance Compliance Division of the Illinois Workers' Compensation Commission, as a witness at hearing before Commissioner Donohoo on February 18, 2014.

2. Prior to hearing, the parties stipulated to the period of non-insurance, 562 days from November 16, 2008 to June 1, 2010.

3. Investigator Stumph testified that he utilized various databases to determine that Respondent had a period of compliance before the period of non-insurance.

4. Based upon the stipulated period of non-insurance, Investigator Stumph calculated a fine of $500 per day, or $281,000.

5. Investigator Stumph noted that Respondent's last premium for workers' compensation insurance was $33,901.00. Dividing that number by 365 resulted in $98.56 per day as the savings enjoyed by Respondent by failing to purchase coverage. The total saved by Respondent over 562 days was $52,198.56.

6. Investigator Stumph explained that the total fine sought was $281,000.00, representing $500 per day, plus the $52,198.56 saved by Respondent by not purchasing the statutorily required insurance, for a total fine of $327,198.56.

7. Investigator Stumph testified that he did not include the $36,147.85 paid out by the Fund in Case No. 10 WC 25510, as that amount was discharged in Respondent Bloomfield's bankruptcy.

8. Petitioner introduced records from NCCI, IDES, Department of Revenue, and the U.S. Bankruptcy Court. PX6-11.

9. Investigator Stumph also provided a summary of his actions in this investigation.
   - On January 20, 2011, he sent a letter of inquiry and notice of non-compliance to Respondent Broomfield and explained in a phone conversation what steps Petitioner would take if the Injured Worker Benefit Fund paid any settlement or award in Herbert Boker's claim.
   - On May 20, 2013, Investigator Stumph received notice that the Fund would pay out $36,147.85 in Case No. 10 WC 25510.
   - On May 21, 2013, Investigator Stumph sent notice of hearing to Respondent Broomfield.
   - On June 14, 2013, Investigator Stumph emailed Respondent a settlement offer in follow up to a phone conversation in which Respondent agreed to try to secure a loan for the settlement amount.
   - On July 16 and July 30, 2013, Respondent phoned Investigator Stumph and advised him he was still trying to obtain a loan to pay the settlement amount.
   - On August 20, 2013, Respondent and his attorney met with Investigator Stumph at the Collinsville review docket. Respondent asked for a continuance to November 18, 2013, which was granted by Commissioner Donohoo.
   - On November 18, 2013, Respondent and his attorney asked for and received another continuance to February 18, 2014.
   - On February 14, 2014, Respondent's attorney advised Investigator Stumph that Respondent Broomfield had declared bankruptcy and the debt he owed the Injured Workers' Fund had been discharged. Investigator Stumph advised the attorney that Respondent would be fined for non-compliance, and Respondent's bankruptcy attorney agreed that the fine or penalty would not be dischargeable in Respondent's bankruptcy proceedings.

10. A hearing was held before Commissioner Donohoo in Collinsville on February 18, 2014. Investigator Stumph was the sole witness, and Respondent offered no testimony and no evidence in defense.

Section 4 of the Act, providing for penalties and fines for non-compliance, was codified July 1, 2005. We find that Respondent is subject to the Act as an employer. Section 4 of the Act requires all employers within the purview of the Act to provide workers' compensation insurance for the protection of their employees. The Commission finds that Respondent was in violation of Section 4(a) of the Act for a period of 562 days, from November 16, 2008 to June 1, 2010.

The Commission further finds that Respondent willfully and knowingly failed to acquire workers' compensation insurance for 562 days. It is evident that Respondent was aware that he was operating a business without workers' compensation insurance. The Commission orders Respondent to pay the statutory minimum, $10,000.00, plus the amount of the premium saved by Respondent's non-compliance, $98.56 per day for 562 days, or $52,198.56, for a total fine of $62,198.56.

15IWCC0070

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent, Thomas D. Broomfield, pay to the Illinois Workers' Compensation Commission the sum of $62,198.56, as provided in Section 4 of the Act.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $62,300.00. The Party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JAN 2 6 2015

Daniel R. Donohoo

Charles J. DeVriendt

Ruth W. White

drd/dak
r-02/18/14
68

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

DEBORAH A. RETKOFSKY,

Petitioner,

15IWCC0071

vs.

NO: 13WC18090

ADVOCATE CHRIST HOSPITAL,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, temporary 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 9, 2014, is hereby affirmed and adopted.

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

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

15IWCC0071

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: JAN 2 8 2015
o1/13/15
RWW/rm
046

Ruth W. White

Charles J. DeVriendt

Daniel R. Donohoo

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

15IWCC0071

RETCOFSKY, DEBORAH A
Employee/Petitioner

Case# **13WC018090**
13WC018089

ADVOCATE CHRIST HOSPITAL
Employer/Respondent

On 6/9/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% 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:

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CHICAGO, IL 60602

2461 NYHAN BAMBRICK KINZIE & LOWRY PC
KAREN HAARSGAARD
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602

15IWCC0071

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)

DEBORAH A. RETCOFSKY,
Employee/Petitioner

Case # 13 WC 18090

Consolidated cases: 13 WC 18089

v.

ADVOCATE CHRIST HOSPITAL,
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **BRIAN CRONIN**, Arbitrator of the Commission, in the city of **CHICAGO**, on **9/16/13, 10/18/13** and **11/21/13**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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: Evidentiary ruling

FINDINGS 15IWCC0071

On the date of accident, **May 3, 2013**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$20,883.72**; the average weekly wage was **$401.64**.

On the date of accident, Petitioner was **51** years of age, ***married*** with **0** dependent children.

Respondent shall be given a credit of **$688.50** in TTD in addition to wages paid for May 7, May 9 and May 10, 2013 in the amount of **$223.20** for a total credit of **$911.70**. (This credit applies to both this case and to consolidated case # 13 WC 18090)

ORDER

Denial of benefits

Based on the Arbitrator's findings of fact and conclusions of law with regard to the issues of accident and causation, the Arbitrator denies compensation.

Evidentiary ruling

Based on the Arbitrator's findings of fact and conclusions of law, the Arbitrator strikes Susan Bozek's testimony of October 18, 2013.

All other issues are moot.

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

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

Signature of Arbitrator

June 5, 2014
Date

ICArbDec19(b)

JUN 9 - 2014

Retcofsky v. Advocate Christ Hospital: 13 WC 18090

15IWCC0071

Findings of Fact:

On May 2, 2013 and May 3, 2013, the petitioner, Deborah A. Retcofsky, was a 51-year-old cafeteria worker in respondent's 95th Street Café, which is located in Advocate Christ Hospital. Petitioner's employment with the respondent required her to stock food and utensils, work as cashier, serve customers food, sweep and wipe down the cafeteria counters and tables. Her work hours were from 6:30 a.m. to 2:30 p.m.

The petitioner was hired to work in the respondent's cafeteria on August 27, 2012.

The petitioner acknowledged that prior to May 2, 2013, she experienced low back pain that radiated down her left leg in May, June and July of 2012. At that time, Dr. Jovanovic, her family physician, treated her for such symptoms and referred her to Dr. Angelopoulos, an interventional pain specialist. Dr. Angelopoulos administered an L4-5 epidural injection. In Dr. Angelopoulos' letter, dated May 31, 2012, he wrote, *inter alia*, the following: "Pt. denies any injury, although she has started a new job which requires a lot more physical labor than she is used of (sic)." (Px2)

Dr. Jovanovic's August 15, 2012, Progress Notes do not contain any complaints of low back pain or lower extremity radicular pain.

Prior to May 2, 2013, the petitioner had no complaints of pain or soreness in her neck, right shoulder or right arm.

On May 2, 2013, the petitioner was at work and was preparing the respondent's yogurt bar for breakfast. The petitioner testified that at approximately 9:30 a.m., she lifted a basket of oranges that were stacked 3-4 tiers high, on top of the yogurt bar. The petitioner "would guestimate" that such basket weighed 20-25 pounds. She lifted the basket with both hands "above shoulder level, above eye level."

While lifting the basket of fruit, the petitioner tried to catch some of the oranges when they began to roll out of the basket. The petitioner testified that at that time, she felt something "pop" in the back of her neck and shoulder on the right side. She then experienced a shooting pain down her right arm followed by numbness and tingling and a pins and needles sensation into her right hand. As the petitioner continued to work, she felt her right hand become numb. A co-employee told the petitioner to report this injury to her supervisor, Susan Bozek. An accident report was filled out (Rx2) and the petitioner was sent to the employee health unit at Advocate Christ Hospital.

The petitioner was examined at the respondent's employee health unit that day. (Px1) Her dominant right arm was placed in a sling. The doctor prescribed pain medication, advised her to ice the arm and to return to work with the use of only her left arm and hand and to follow up in four days. (Px1)

The petitioner returned to work the next day, May 3, 2013, with her right arm in a sling. The petitioner testified that Susan Bozek asked her if she would perform cashier duties. However, the petitioner declined such duties because she was fearful she would miscount the money since she could only use her non-dominant left arm. Ms. Bozek then instructed the petitioner to perform stocking duties. The petitioner testified that such duties required her to bend over and pull out boxes of "plasticware", napkins and silverware, to lift such supplies onto the counter and then to re-stock the cafeteria containers. The petitioner testified that she also helped out with the salad bar by re-stocking tuna or lettuce and

writing up tags for the items. She also had to take stock, such as cases of yogurt, out of refrigerator. She used the cart as much as possible.

The petitioner testified that Ms. Bozek instructed her to restock the (potato) chip rack. This required the petitioner to rotate and re-stock shelves that held bags of chips. She testified that the chip rack extends from shoulder level to two inches above the floor. Such activity, she testified, required bending and stooping and felt very awkward because she had to put so much of the left side of her body into this work.

The petitioner testified that by the end of her shift on May 3, 2013, she experienced quite a bit of low back pain. She characterized the pain as "very sharp, very strong intense" and in the same location as the pain she felt in May, June and July of 2012.

On cross-examination, the following exchange took place:

Q: Ms. Retcofsky, can you tell me why you did not talk to your supervisor and have a new accident report filled out if you hurt another part of your body?

A: Because I didn't know what specific thing I was doing that injured it, because I have a lower back problem.

Q: Okay. It was your testimony?

A: And it was only aching on Friday.

Q: Okay.

A: My back was aching. It was hurting.

Q: Had your back ached before that Friday between that time and when you started working at Advocate on August 27, 2012?

A: No, not really.

Q: So you didn't think it was an incident that you should have had to have reported?

A: I just assumed it was because I have a lower back problem. I was only working with one side of my body.

On Saturday, May 4, 2013, the petitioner returned to work for the respondent. At that time, the petitioner testified, she was in "a lot of pain." She felt pain in her back, her neck, her right arm and her right shoulder. The petitioner was scheduled to set up the yogurt bar, but when she arrived that morning, she discovered that her department manager had already set up the yogurt bar.

The petitioner testified that she was again required to use only her left arm to re-stock the yogurt/salad bar. The petitioner's co-workers assisted her as much as possible in performing heavier work.

At the hearing, the petitioner identified some of the bulk products she was required to lift and manipulate with only her left arm. The petitioner testified that on May 4, 2013, she had to pour pickles or olives from a 3 to 5 pound jar into a serving container. To do so she was required to lift the 3 to 5 pound jar and hug it with her left arm against her body. The petitioner testified that she would normally need the use of both hands to control the jar. On that day, however, the she was unable to control the jar and it fell to the floor and the product spilled out of it. One of the petitioner's co-workers, Rickiah Smith, volunteered to clean up the spill for her. The petitioner testified that by the end of her workday, she felt "a lot of pain" in her low back and could barely walk. With respect to her right shoulder and arm, the petitioner testified that at the end of her workday, she felt a lot of pain. She had been icing her shoulder and arm throughout the shift.

The petitioner returned to work the next day, Sunday, May 5, 2013. She testified that she was in severe pain in her neck, shoulder, down her arm, in her lower back and now shooting pain into her left leg. The petitioner was scheduled to do the yogurt bar stock set-up, but all of her co-workers were pitching in and helping her. The petitioner testified that she was "just doing more bending with the plastic ware and filling that type of stuff." The petitioner testified that after working for approximately 1-1/2 hours that morning, she was in excruciating pain, could barely walk and was in more pain than when she started the day.

The petitioner testified that on Sunday, May 5, 2013, she informed her lead manager, Shantris, that she was in excruciating pain. The petitioner testified that she told Shantris that she could barely walk, to which Shantris responded: "I can see that, honey." The petitioner testified that Shantris sent her home that morning and told her to follow up at the employee health unit.

The respondent did not call Shantris to testify.

On the following Monday, May 6, 2013, the petitioner was previously scheduled to be off work. On that day, however, the petitioner reported to the employee health unit at Advocate Christ Hospital. The record reflects that her chief complaint was right shoulder pain, which she described as constant aching that is made worse by lifting and improved with nothing. (Px1) The record also indicates that she has been unable to get more than a couple of hours of sleep at night despite taking the Vicodin and cyclobenzaprine medications. (Px1) The record then indicates the following: "She also complains today of her back starting to hurt like it did a few years ago, but she does not relate it to a specific work incident. Also, it did not start until after she got home after work." (Px1) The petitioner testified that she told Dr. Greene at employee health about her low back pain and that she could hardly walk. The petitioner testified that Dr. Greene would not treat her for her low back pain and referred her to her own physician for those complaints. The petitioner testified that Dr. Greene did refer her to an orthopedist for her neck complaints and continued to restrict her to left-armed work only.

Dr. Jovanovic's "Telephone Encounter" record, dated May 6, 2013, indicates that the petitioner telephoned the doctor's office and left the following message:

"Last Thur she hurt (R) shoulder at work. Been working just using her (L) side.

Has problem with back disc & has had an epidural. Has had no problem with

back since. She needs to be seen because they have her on light duty (she works

in the cafeteria) but her back is now giving her alot (sic) of pain. She thinks it is

because she is just using her (L) side. See her?" (Px2)

The May 7, 2013 Progress Note of Dr. Dragisic, a colleague of Dr. Jovanovic's, indicates in the "Reason for Appointment" section that the petitioner had complaints of hurting her right shoulder at work the previous Thursday and is now having low back pain (sciatica). (Px2) Under "Assessments", Dr. Dragisic listed the following:

1. Unspecified disorders of bursae and tendons in shoulder region – 726.10 (Primary)
2. Essential hypertension, benign – 401.1
3. Lumbago – 724.2
4. Sciatica – 724.3
5. Thoracic and lumbosacral neuritis or radiculitis, unspecified – 724.4
6. Cervicalgia – 723.1
7. Cervicocranial syndrome – 723.2
8. Unspecified musculoskeletal disorders and symptoms referable to neck – 723.9

The records also show that Dr. Dragisic sought approval to treat the petitioner for her work injuries and was advised by Kim Romo, respondent's workers' compensation manager, that the petitioner could only see one physician. Dr. Dragisic prescribed medication and an MRI of petitioner's right shoulder. He advised that the petitioner could not return to work until further evaluation. (Px2)

On May 9, 2013, the petitioner underwent an MRI of her right shoulder, without contrast. The radiologist offered the following impression of MRI of petitioner' right shoulder MR images:

1. Moderate chronic and acute degenerative changes at the acromioclavicular joint could represent a primary source for pain and could contribute to impingement.
2. Mild supraspinatus tendinopathy without tearing.
3. Mild subacromial/subdeltoid bursitis.
4. Moderate acromial sloping. (Px2, Px3)

The petitioner returned to Dr. Dragisic on May 14, 2013 without any improvement. Dr. Dragisic prescribed an MRI of petitioner's cervical spine. (Px2)

On May 22, 2013, the petitioner underwent an MRI of the cervical spine, without contrast. The radiologist offered the following impression of the images:

1. At C5-C6 level, mild bilateral foraminal stenosis due to disc osteophyte complex.
2. At C6-C7 level, subtle broad-based disc bulge that abuts the thecal sac. (Px2, Px3)

On May 23, 2013, the petitioner underwent an EMG/NCS study of her upper extremities. The physician offered the following impression of the electrodiagnostic findings:

The above electrical study is consistent with bilateral median neuropathies at the

wrist/carpal tunnel syndrome. This condition is of mild intensity on the right side

and of borderline/mild intensity on the left side. (Px2, Px4)

On May 28, 2013 the petitioner returned to Dr. Dragisic. This doctor recorded: "MRI-c-spine confirms HNP at c-spine" and "EMG r > l CTS." Dr. Dragisic referred the petitioner to Dr. Angelopoulos for pain treatment (Px5a, Px5b), and restricted her to no lifting of anything over five pounds and no bending or stooping. The petitioner's job duties were discussed and it was determined that she could try the cashier position now that her dominant right arm was no longer in a sling. (Px2)

The petitioner testified that she returned to work with a note from the doctor and gave it to Ms. Katherine.

In Dr. Dragisic's medical records, there is a handwritten note dated 5/28/13 in which Dr. Dragisic wrote, in pertinent part, the following: "She is medically required to have light duty work only until further notice." (Px2)

The petitioner testified that Linda Ozman, her manager, told her that before she could return to work, she needed to have a more detailed note from her doctor that listed exactly how many pounds she could lift and exactly what she can and cannot do.

Prior to May 2, 2013, the petitioner had scheduled time off work from May 31, 2013 through June 3, 2013. During that time period, the petitioner embarked on a seven-hour bus trip to Minnesota to attend her granddaughter's dance recital. The petitioner did not drive to Minnesota.

On June 5, 2013, the petitioner was allowed to return to work at the cashier position. Due to her continuing low back pain, the petitioner testified, she was unable to stand more than one hour. The petitioner testified that the pain would travel down her left leg to the knee. The toes of her left foot would start going numb. The following day, the petitioner was given the day off in order to see Dr. Angelopoulos. It was decided that the petitioner would receive an injection to her low back before Dr. Angelopoulos attended to petitioner's neck complaints.

The first injection took place on June 12, 2013. The petitioner was unable to work through June 17, 2013, after which she returned to work at the cashier position. The petitioner testified that standing at the cashier position continued to exacerbate her low back pain.

The petitioner was scheduled to undergo a second injection on June 26, 2013. That injection was cancelled as the petitioner was required to work that day.

The petitioner testified that she asked for a work accommodation. She requested the use of a stool in the cashier's booth so that she could alternate standing and sitting positions in order to relieve the pain. Her request was denied. The petitioner testified that the continuous standing caused her low back pain to increase during the work hours.

On June 26, 2013, the petitioner worked on her feet at the cashier's station all day long. The petitioner testified that her low back pain became intense. After work, the petitioner went to the emergency room at Advocate Christ Hospital. (Px6) Those records indicate that the petitioner suffered from right shoulder and arm pain as well as low back pain. She was advised to remain off of work and to see her own physicians.

The petitioner returned to Dr. Angelopoulos on July 3, 2013 and was given a cervical ESI. She was again allowed to return to light-duty work. The petitioner testified that she did return to work on July 4, 2013, but was unable to work the whole day because she was in too much pain in her neck, right shoulder, lower back and left leg.

The petitioner testified that she tried to return to work on July 5, 2013, but was in too much pain and ended up in the Advocate Christ Hospital emergency room. The emergency room physicians noted that the petitioner had chronic back pain aggravated by her work injury. The emergency room physicians suggested that the petitioner see a neurosurgeon.

On July 8, 2013, the petitioner returned to Dr. Dragisic, who prescribed a lumbar MRI and took the petitioner off of work. (Px2)

The lumbar MRI took place on July 12, 2013. The radiologist, Amjad Safvi, M.D., offered the following impression:

1. Mild to moderate scoliosis of the lumbar spine with convexity towards the left side.
2. At L3-L4 and L4-L5 levels, subtle broad based disc bulge that abuts the thecal sac. Significance of this may be correlated clinically.
3. Comparison is made with previous MRI of lumbar spine without contrast from 05/15/2012. There is no significant change in findings. (Px2)

On July 17, 2013, the petitioner returned to Dr. Dragisic who again released the petitioner to work as a cashier only with use of a stool to sit and stand as necessary. Petitioner was also referred to orthopedic specialist, Dr. Zindrick.

On July 19, 2013, Dr. Zindrick saw the petitioner. Dr. Zindrick reviewed petitioner's MRIs and performed an examination. His diagnosis was that the petitioner suffered from lumbar and cervical degenerative disc disease aggravated by the work-related accident of May 2, 2013. Dr. Zindrick took the petitioner off of work and recommended physical therapy and medication. The petitioner began a course of physical therapy at ATI.

The petitioner returned to Dr. Zindrick on August 16, 2013. He noted that she was a little better with physical therapy. However, the pain still wakes her up at night. The petitioner was continued off work, was prescribed Norco and was advised to continue physical therapy that advanced to work conditioning.

On August 19, 2013, the petitioner underwent a §12 examination by Dr. Ghanayem. The petitioner testified that the examination took approximately eight minutes. Dr. Ghanayem opined that, based on the mechanism of injury, the petitioner sustained a muscle sprain of her neck on May 2, 2013. He deferred any opinion with regard to the petitioner's right shoulder condition. Further, Dr. Ghanayem found degenerative changes at L4-L5, L3-L4 and L2-L3. Dr. Ghanayem opined that these findings are minimal and clearly age appropriate. There is nothing compressive or traumatic. Dr. Ghanayem further opined: "With regards to her lumbar spine, all I can find today is nonorganic pain behaviors." Dr. Ghanayem opined that the petitioner required no further medical care and can return back to work at regular duty. (Rx1)

The respondent called Susan Bozek to testify. Ms. Bozek was petitioner's manager or "lead" on May 2, 2013. Ms. Bozek testified that Rx5, a photograph, represents a typical crate of oranges that is placed on the salad bar/yogurt bar. Yet, on cross-examination, Ms. Bozek testified that she did not see the tray of oranges that the petitioner lifted on May 2, 2013, and did not know how high it was stacked. Ms. Bozek did not recall which of the petitioner's arms had been placed in a sling after she returned from the employee health facility. Ms. Bozek testified that the petitioner was upset that employee health did not allow her to remain off of work. Therefore, as petitioner's manager, she allowed the petitioner to do limited work. Ms. Bozek testified that the she was unaware of petitioner's low back complaints until weeks after the May 2, 2013 incident and that she never, at any time, instructed the petitioner to restock the chip rack which the petitioner testified required her to bend and stoop while using only her left arm to perform the stock duties.

Ms. Bozek also testified several times while under oath, that the petitioner was not even at work on May 3, 2013, the date petitioner testified she was required to perform stock duties using just her left arm and hand. Ms. Bozek indicated that she was positive that the petitioner was not at work on May 3, 2013 based upon her personal knowledge.

The respondent called Terri Green as its witness. Prior to the respondent stipulating that the petitioner was at work on May 3, 2013, the date petitioner alleges that the stock duties initiated her current low back pain, Ms. Green testified. Terri Green testified that the petitioner worked the morning shift, from 6:00 a.m. to 2:30 p.m. Ms. Green testified that she did not recall seeing the petitioner on May 3, 2013.

Ms. Green testified that she worked with the petitioner on Saturday, May 4, 2013, during the morning shift, from 6:00 a.m. to 2:30 p.m. Ms. Green testified that she was able to observe the petitioner wiping down the countertops. Ms. Green testified that the petitioner did not lift anything at work that day.

The respondent also called Rickiah Smith, another of petitioner's co-workers. Ms. Smith testified that she did not know if she worked on May 3, 2013, the date that the petitioner injured her lower back. Ms. Smith testified that she did work on Saturday, May 4, 2013 where she also observed the petitioner wiping counter tops. Ms. Smith testified that the petitioner did not lift anything on May 4, 2013. On cross-examination Ms. Smith testified that she did not begin working on May 4, 2013 until 2:30 p.m. Ms. Smith testified that she cleaned up the olives that the petitioner had spilled, but did not see the petitioner drop the jar.

The petitioner sought to bifurcate the trial to produce evidence that she was at work on May 3, 2013. The matter was continued to October 18, 2013 to close proofs. Prior to presenting more testimony, the respondent stipulated that it had presented incorrect testimony about its claim that the petitioner had not been at work on May 3, 2013 since its records confirmed that the petitioner was at work during May 3, 2013.

Dr. Zindrick, the petitioner's treating orthopedic surgeon, assessed the petitioner with cervical and lumbar degenerative disc disease aggravated by her work related injuries. Dr. Dragisic opined that the petitioner's right shoulder MRI demonstrates impingement. The petitioner remains under the care of Dr. Zindrick and Dr. Dragisic. The petitioner was referred back to Dr. Angelopoulos for a facet joint

injection into her lower back. At the time of trial, Dr. Zindrick continued to keep the petitioner off of work and referred her for an FCE.

The petitioner testified that she continues to experience pain, soreness and tingling as well as intermittent numbness in her neck, shoulder, right arm down into her hand. This continues on a daily basis. She notes weakness in her right arm. The petitioner further testified that she continues to experience pain in her low back radiating down into her left leg. She is unable to stand for long periods. Sitting for an hour causes the pain to become severe. Her condition is not improving. The petitioner wishes to continue treatment with Dr. Zindrick, Dr. Angelopoulos and Dr. Dragisic.

Conclusions of Law:

In support of his decision in regard to issues (C) "Did an accident occur that arose out of and 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 makes the following findings of fact and conclusions of law:

In her Application for Adjustment of Claim for case number 13 WC 18089, the petitioner alleges, *inter alia*, the following:

Date of accident: **May 2, 2013**
How did the accident occur?: **Lifting Basket of Fruit**
What part of the body was affected?: **Upper Back; Right Shoulder; Right Arm; Low Back**
What is the nature of the injury? **To Be Shown**

In her Application for Adjustment of Claim for case number 13 WC 18090, the petitioner alleges, *inter alia*, the following:

Date of accident: **May 3, 2013**
How did the accident occur?: **Stocking Products While Restricted to Use Left Arm Only**
What part of the body was affected?: **Low Back; Legs**
What is the nature of the injury? **To Be Shown**

In the Employee Report of Occupational Injury or Illness, which the petitioner signed and dated "5/2/13", Susan Bozek wrote that the injured body part was the right shoulder and the injury happened when "Deb was lifting fruit off salad bar (yogurt bar) and she felt a pull and pain in shoulder." (Rx2) There is no mention in the report of any low back and leg pain. (Rx2)

Furthermore, there is no mention by Dr. Greene in the May 2, 2013 employee health record of any low back or leg pain complaints by the petitioner.

The petitioner testified that she sustained a low back injury on May 3, 2013 that was not the result of a single, traumatic incident at work. Dr. Greene confirmed this statement in the employee health record of May 6, 2013, but added: "Also it did not start until after she got home after work."

The petitioner claims that her back pain progressed slowly as the weekend went on.

Yet, the petitioner performed light-duty work on May 3, 4 and 5, 2013. According to the petitioner, the heaviest item that she lifted - - and she testified to doing this on a single occasion over 2-1/4 days of work - - was a 3-5 pound jar of pickles or olives. Other items that she lifted included cups, plastic ware, cartons of milk and cartons of yogurt. She replenished the chip rack. She wiped counters and tables.

The petitioner testified that she told Shantris on May 5, 2013 that she was in excruciating pain and could barely walk. However, the petitioner clearly testified that did not tell Shantris *where* she had the pain. (Italics added) (Tr.46) When Dr. Greene saw her at the employee health unit the next day, he recorded that her primary problem is constant aching and numbness in her right shoulder and that such shoulder pain increases significantly with movement of the right arm. (Px1)

The petitioner attributes her back pain to the shifting of her body weight to the left while she performed her job duties since she did not have the use of her right arm. Therefore, the Arbitrator concludes that the petitioner is claiming a repetitive trauma with an accident date of May 3, 2013 that stemmed from the accident of May 2, 2013.

An employee who suffers a repetitive trauma injury may apply for benefits under the Act but must meet the same standards of proof as an employee who suffers a sudden injury. Durand v. Indus. Comm'n, 862 N.E.2d 918, 924-925 (2006)

There must be a showing that the injury is work-related and not the result of a normal degenerative aging process. Peoria County Belwood Nursing Home v. Indus. Comm'n, 505 N.E.2d 1026 (1987)

In cases relying on the repctitive trauma concept, the claimant generally relies on medical testimony establishing a causal connection between the work performed and claimant's disability. Williams v. Indus. Comm'n, 614 N.E.2d 177, 180 (1st Dist. 1993)

The May 7, 2013 Progress Note of Dr. Dragisic indicates in the "Reason for Appointment" section that the petitioner had complaints of hurting her right shoulder at work the previous Thursday and is now having low back pain (sciatica).

Dr. Dragisic referred the petitioner to Dr. Angelopoulos. When Dr. Angelopoulos saw the petitioner on June 12, 2013, he took a history of present illness from her. He wrote, in pertinent part, the following: "She was initially sent back to work with light duty restrictions and her right upper extremity in a sling. While working with using only with her left arm, she then injured her lower back again. The left low back and left buttock and leg complaints are consistent with what she was experiencing last summer." (Px2)

In a "To Whom It May Concern" letter dated July 17, 2013, Dr. Dragisic, a family medicine physician, wrote the following statement: "Mrs. Retcofsky is being treated by me for neck, shoulder and low back pain, related to a work injury." (Px2) Yet, Dr. Dragisic does not give the basis for his causation opinion as it relates to the low back nor does he identify whether the back pain relates to the activities of May 2, 2013 or May 3, 2013.

On July 19, 2013, Dr. Zindrick first saw the petitioner. Dr. Zindrick is an orthopedic surgeon associated with Hinsdale Orthopaedics. He took a history that included, in pertinent part, the following:

"Deborah is a 51-year-old white female that works for the food service for Christ Medical Center. She was injured at work lifting fruit baskets on 05/02/2013. She had neck pain and shoulder pain she (sic)

saw employee health was (sic) told to take it easy for a few days she (sic) was placed in a new position to stock not using her right arm. She returned to work Friday, Saturday and half-day Sunday but due to disposition (sic) experience severe increasing low back pain. And she went home after a half day on Sunday. On 05/06/2013 she was back in employee health with complaints of low back pain and was told this was unrelated. Apparently no new injury report was filled out. She last worked 07/05/2013 (sic) she attempt (sic) to return to work with restrictions but was standing on the cash register and this caused increasing pain."

Dr. Zindrick conducted a physical examination and reviewed the results of the imaging studies. Dr. Zindrick then offered the following impression:

"Pre-existing cervical and lumbar degenerative disc disease aggravated by work-related injuries. Cervical injury occurred at work on 05/02/2013 and lumbar injuries subsequent to that upon return to work doing stocking over the weekend of May 3, 4 and 5."

The Arbitrator finds Dr. Zindrick's causation opinion to be inaccurate and incomplete. First, he wrote that she was lifting fruit baskets, not *a* fruit basket after which she sustained neck and shoulder pain. (Emphasis added.) Second, the petitioner was performing light-duty work on May 3, 4 and 5, 2013. There is no evidence that Dr. Zindrick was aware of the weights of the items that the petitioner lifted while stocking or the frequency of the lifting and bending that the petitioner did on May 3, 4 and 5, 2013.

The Arbitrator also finds Dr. Dragisic's causation opinion to be deficient.

The Commission is not required to accept a causal connection opinion when it is based on flawed, inaccurate or incomplete histories. Sorenson v. Indus. Comm'n, 666 N.E.2d 713 (4th Dist. 1996)

On August 19, 2013 report, the petitioner underwent a Section 12 examination by Dr. Ghanayem. Dr. Ghanayem is a professor and orthopedic surgeon associated with Loyola University Medical Center. In his examination report, Dr. Ghanayem wrote: "She then states that she was put back at light duty and was doing things, such as restocking the salad bar, utensils and activities of that nature, when she developed back pain. She could not report a specific incident or event. She thinks it just occurred throughout the course of the workday." Following his physical examination of the petitioner's low back, Dr. Ghanayem wrote: " . . . all I can find today are nonorganic pain behaviors."

In his July 12, 2013 Imaging Report of the MR images taken of the petitioner's lumbar spine that day, Radiologist Amjad Safvi wrote: "There is no significant interval change in findings." In fact, Dr. Safvi's impression of the MR images taken of the petitioner's lumbar spine on May 15, 2012 is as follows:

1. Mild to moderate scoliosis of the lumbar spine with convexity towards the left side.
2. At L3-L4 and L4-L5 levels, subtle disc bulge that abuts the thecal sac. Significance of this may be correlated clinically. (Px5a)

The Arbitrator questions the credibility of Ms. Bozek who testified that the petitioner did not work on May 3, 2013 based upon her personal knowledge. The respondent has not offered any testimony with regard to the petitioner's duties on May 3, 2013.

The Arbitrator also questions the petitioner's credibility. Although Susan Bozek testified as to her observations on May 4, 2013, she stated that petitioner was upset about not being taken completely off

work following the fruit basket accident and further that the petitioner did not go home that day because the petitioner was concerned about absenteeism issues. The petitioner had exhausted her leave time and could not call off. Dr. Greene's May 6, 2013 entry - - - which contains the first documented complaints of the petitioner's low back pain - - - clearly indicates that her back pain began after she returned home from work. The petitioner then revised this history when she left a phone message with Dr. Jovanovic's office later that day. Moreover, the petitioner testified that Rx5 was not accurate depiction of the fruit basket she lifted on May 2, 2013 since she stacked the basket that day with oranges three to four tiers high.

There is no evidence that on May 3, 4 or 5, 2013, the petitioner complained to anyone of low back pain.

The Arbitrator finds that the petitioner failed to prove that the light lifting and occasional bending she performed on May 3, 2013 resulted in a repetitive trauma to her low back. Therefore, by a preponderance of the evidence, the Arbitrator finds that the petitioner failed to prove that on May 3, 2013 she sustained an accident that arose out of and in the course of her employment with the respondent and further failed to prove that her current condition of ill-being of her low back is causally related to her work activities of May 3, 2013.

In support of his decision in regard to issues (O) Evidentiary ruling, the Arbitrator makes the following findings of fact and conclusions of law:

The recall of a witness in order to allow a party to elicit further testimony during its case in chief is within the sound discretion of the trial court where the testimony does not contradict the witness' earlier testimony and the other party has had ample opportunity to cross-examine the witness and is not prevented from preparing its case to counter the additional testimony. People v. Clark, 178 Ill.App.3d 849, 853 (1989)

The Arbitrator finds that based upon the respondent's admission on the record at the commencement of the October 18, 2013 hearing, the additional testimony of Susan Bozek was offered specifically for the purpose of contradicting her earlier testimony of September 16, 2013. Therefore, the Arbitrator strikes Susan Bozek's testimony of October 18, 2013.

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

DEBORAH A. RETCOFSKY,

Petitioner,

15IWCC0072

vs.

NO: 13WC18089

ADVOCATE CHRIST HOSPITAL,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 9, 2014, 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.

15IWCC0072

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $3,200.00. 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: JAN 2 8 2015
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RWW/rm
046

Ruth W. White

Charles J. DeVriendt

Daniel R. Donohoo

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

15IWCC0072

RETCOFSKY, DEBORAH A
Employee/Petitioner

Case# **13WC018089**
13WC018090

ADVOCATE CHRIST HOSPITAL
Employer/Respondent

On 6/9/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% 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:

0311 KOSIN LAW OFFICE LTD
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CHICAGO, IL 60602

2461 NYHAN BAMBRICK KINZIE & LOWRY PC
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CHICAGO, IL 60602

15IWCC0072

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)

DEBORAH A. RETKOFSKY,
Employee/Petitioner

v.

ADVOCATE CHRIST HOSPITAL,
Employer/Respondent

Case # **13 WC 18089**

Consolidated cases: **13 WC 18090**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **BRIAN CRONIN**, Arbitrator of the Commission, in the city of CHICAGO, on **9/16/13, 10/18/13** and **11/21/13**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

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

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

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

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

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

G. [ ] What were Petitioner's earnings?

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

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

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

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

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

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

N. [ ] Is Respondent due any credit?

O. [ ] Other

FINDINGS 15IWCC0072

On the date of accident, **May 2, 2013**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$20,883.72**; the average weekly wage was **$401.64**.

On the date of accident, Petitioner was **51** years of age, ***married*** with **0** dependent children.

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

Respondent shall be given a credit of **$688.50** TTD, in addition to wages paid for May 7, May 9 and May 10, 2013 in the amount of **$223.20** for a total credit of **$911.70**. (This credit applies both to this case and to consolidated case # 13 WC 18090.)

ORDER

Temporary Total Disability Benefits

Respondent shall pay Petitioner temporary total disability benefits of **$267.76**/week for **11-5/7** weeks, for dates of **5/7/13 - 6/4/13, 6/26/13 - 7/3/13** and **7/6/13 - 8/19/13**, as provided in Section 8(b) of the Act.

Medical benefits

Respondent shall pay the charges associated with the reasonable and necessary medical services rendered to the petitioner directly to the providers, as delineated in the body of this decision (please see conclusions of law on page 10), for treatment to her cervical spine and right shoulder that was rendered between May 2, 2013 and August 19, 2013, pursuant to Section 8(a) and subject to Section 8.2 of the Act.

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

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

Signature of Arbitrator

June 5, 2014
Date

ICArbDec19(b)

JUN 9 - 2014

Findings of Fact:

On May 2, 2013 and May 3, 2013, the petitioner, Deborah A. Retcofsky, was a 51-year-old cafeteria worker in respondent's 95th Street Café, which is located in Advocate Christ Hospital. Petitioner's employment with the respondent required her to stock food and utensils, work as cashier, serve customers food, sweep and wipe down the cafeteria counters and tables. Her work hours were from 6:30 a.m. to 2:30 p.m.

The petitioner was hired to work in the respondent's cafeteria on August 27, 2012.

The petitioner acknowledged that prior to May 2, 2013, she experienced low back pain that radiated down her left leg in May, June and July of 2012. At that time, Dr. Jovanovic, her family physician, treated her for such symptoms and referred her to Dr. Angelopoulos, an interventional pain specialist. Dr. Angelopoulos administered an L4-5 epidural injection. In Dr. Angelopoulos' letter, dated May 31, 2012, he wrote, *inter alia*, the following: "Pt. denies any injury, although she has started a new job which requires a lot more physical labor than she is used of (sic)." (Px2)

Dr. Jovanovic's August 15, 2012, Progress Notes do not contain any complaints of low back pain or lower extremity radicular pain.

Prior to May 2, 2013, the petitioner had no complaints of pain or soreness in her neck, right shoulder or right arm.

On May 2, 2013, the petitioner was at work and was preparing the respondent's yogurt bar for breakfast. The petitioner testified that at approximately 9:30 a.m., she lifted a basket of oranges that were stacked 3-4 tiers high, on top of the yogurt bar. The petitioner "would guestimate" that such basket weighed 20-25 pounds. She lifted the basket with both hands "above shoulder level, above eye level."

While lifting the basket of fruit, the petitioner tried to catch some of the oranges when they began to roll out of the basket. The petitioner testified that at that time, she felt something "pop" in the back of her neck and shoulder on the right side. She then experienced a shooting pain down her right arm followed by numbness and tingling and a pins and needles sensation into her right hand. As the petitioner continued to work, she felt her right hand become numb. A co-employee told the petitioner to report this injury to her supervisor, Susan Bozek. An accident report was filled out (Rx2) and the petitioner was sent to the employee health unit at Advocate Christ Hospital.

The petitioner was examined at the respondent's employee health unit that day. (Px1) Her dominant right arm was placed in a sling. The doctor prescribed pain medication, advised her to ice the arm and to return to work with the use of only her left arm and hand and to follow up in four days. (Px1)

The petitioner returned to work the next day, May 3, 2013, with her right arm in a sling. The petitioner testified that Susan Bozek asked her if she would perform cashier duties. However, the petitioner declined such duties because she was fearful she would miscount the money since she could only use her non-dominant left arm. Ms. Bozek then instructed the petitioner to perform stocking duties. The petitioner testified that such duties required her to bend over and pull out boxes of "plasticware", napkins and silverware, to lift such supplies onto the counter and then to re-stock the cafeteria containers. The petitioner testified that she also helped out with the salad bar by re-stocking tuna or lettuce and

writing up tags for the items. She also had to take stock, such as cases of yogurt, out of refrigerator. She used the cart as much as possible.

The petitioner testified that Ms. Bozek instructed her to restock the (potato) chip rack. This required the petitioner to rotate and re-stock shelves that held bags of chips. She testified that the chip rack extends from shoulder level to two inches above the floor. Such activity, she testified, required bending and stooping and felt very awkward because she had to put so much of the left side of her body into this work.

The petitioner testified that by the end of her shift on May 3, 2013, she experienced quite a bit of low back pain. She characterized the pain as "very sharp, very strong intense" and in the same location as the pain she felt in May, June and July of 2012.

On cross-examination, the following exchange took place:

Q: Ms. Retcofsky, can you tell me why you did not talk to your supervisor and have a new accident report filled out if you hurt another part of your body?

A: Because I didn't know what specific thing I was doing that injured it, because I have a lower back problem.

Q: Okay. It was your testimony?

A: And it was only aching on Friday.

Q: Okay.

A: My back was aching. It was hurting.

Q: Had your back ached before that Friday between that time and when you started working at Advocate on August 27, 2012?

A: No, not really.

Q: So you didn't think it was an incident that you should have had to have reported?

A: I just assumed it was because I have a lower back problem. I was only working with one side of my body.

On Saturday, May 4, 2013, the petitioner returned to work for the respondent. At that time, the petitioner testified, she was in "a lot of pain." She felt pain in her back, her neck, her right arm and her right shoulder. The petitioner was scheduled to set up the yogurt bar, but when she arrived that morning, she discovered that her department manager had already set up the yogurt bar.

The petitioner testified that she was again required to use only her left arm to re-stock the yogurt/salad bar. The petitioner's co-workers assisted her as much as possible in performing heavier work.

At the hearing, the petitioner identified some of the bulk products she was required to lift and manipulate with only her left arm. The petitioner testified that on May 4, 2013, she had to pour pickles or olives from a 3 to 5 pound jar into a serving container. To do so she was required to lift the 3 to 5 pound jar and hug it with her left arm against her body. The petitioner testified that she would normally need the use of both hands to control the jar. On that day, however, the she was unable to control the jar and it fell to the floor and the product spilled out of it. One of the petitioner's co-workers, Rickiah Smith, volunteered to clean up the spill for her. The petitioner testified that by the end of her workday, she felt "a lot of pain" in her low back and could barely walk. With respect to her right shoulder and arm, the petitioner testified that at the end of her workday, she felt a lot of pain. She had been icing her shoulder and arm throughout the shift.

The petitioner returned to work the next day, Sunday, May 5, 2013. She testified that she was in severe pain in her neck, shoulder, down her arm, in her lower back and now shooting pain into her left leg. The petitioner was scheduled to do the yogurt bar stock set-up, but all of her co-workers were pitching in and helping her. The petitioner testified that she was "just doing more bending with the plastic ware and filling that type of stuff." The petitioner testified that after working for approximately 1-1/2 hours that morning, she was in excruciating pain, could barely walk and was in more pain than when she started the day.

The petitioner testified that on Sunday, May 5, 2013, she informed her lead manager, Shantris, that she was in excruciating pain. The petitioner testified that she told Shantris that she could barely walk, to which Shantris responded: "I can see that, honey." The petitioner testified that Shantris sent her home that morning and told her to follow up at the employee health unit.

The respondent did not call Shantris to testify.

On the following Monday, May 6, 2013, the petitioner was previously scheduled to be off work. On that day, however, the petitioner reported to the employee health unit at Advocate Christ Hospital. The record reflects that her chief complaint was right shoulder pain, which she described as constant aching that is made worse by lifting and improved with nothing. (Px1) The record also indicates that she has been unable to get more than a couple of hours of sleep at night despite taking the Vicodin and cyclobenzaprine medications. (Px1) The record then indicates the following: "She also complains today of her back starting to hurt like it did a few years ago, but she does not relate it to a specific work incident. Also, it did not start until after she got home after work." (Px1) The petitioner testified that she told Dr. Greene at employee health about her low back pain and that she could hardly walk. The petitioner testified that Dr. Greene would not treat her for her low back pain and referred her to her own physician for those complaints. The petitioner testified that Dr. Greene did refer her to an orthopedist for her neck complaints and continued to restrict her to left-armed work only.

Dr. Jovanovic's "Telephone Encounter" record, dated May 6, 2013, indicates that the petitioner telephoned the doctor's office and left the following message:

"Last Thur she hurt (R) shoulder at work. Been working just using her (L) side.

Has problem with back disc & has had an epidural. Has had no problem with

back since. She needs to be seen because they have her on light duty (she works

in the cafeteria) but her back is now giving her alot (sic) of pain. She thinks it is

because she is just using her (L) side. See her?" (Px2)

The May 7, 2013 Progress Note of Dr. Dragisic, a colleague of Dr. Jovanovic's, indicates in the "Reason for Appointment" section that the petitioner had complaints of hurting her right shoulder at work the previous Thursday and is now having low back pain (sciatica). (Px2) Under "Assessments", Dr. Dragisic listed the following:

1. Unspecified disorders of bursae and tendons in shoulder region – 726.10 (Primary)
2. Essential hypertension, benign – 401.1
3. Lumbago – 724.2
4. Sciatica – 724.3
5. Thoracic and lumbosacral neuritis or radiculitis, unspecified – 724.4
6. Cervicalgia – 723.1
7. Cervicocranial syndrome – 723.2
8. Unspecified musculoskeletal disorders and symptoms referable to neck – 723.9

The records also show that Dr. Dragisic sought approval to treat the petitioner for her work injuries and was advised by Kim Romo, respondent's workers' compensation manager, that the petitioner could only see one physician. Dr. Dragisic prescribed medication and an MRI of petitioner's right shoulder. He advised that the petitioner could not return to work until further evaluation. (Px2)

On May 9, 2013, the petitioner underwent an MRI of her right shoulder, without contrast. The radiologist offered the following impression of MRI of petitioner' right shoulder MR images:

1. Moderate chronic and acute degenerative changes at the acromioclavicular joint could represent a primary source for pain and could contribute to impingement.
2. Mild supraspinatus tendinopathy without tearing.
3. Mild subacromial/subdeltoid bursitis.
4. Moderate acromial sloping. (Px2, Px3)

The petitioner returned to Dr. Dragisic on May 14, 2013 without any improvement. Dr. Dragisic prescribed an MRI of petitioner's cervical spine. (Px2)

On May 22, 2013, the petitioner underwent an MRI of the cervical spine, without contrast. The radiologist offered the following impression of the images:

1. At C5-C6 level, mild bilateral foraminal stenosis due to disc osteophyte complex.
2. At C6-C7 level, subtle broad-based disc bulge that abuts the thecal sac. (Px2, Px3)

On May 23, 2013, the petitioner underwent an EMG/NCS study of her upper extremities. The physician offered the following impression of the electrodiagnostic findings:

The above electrical study is consistent with bilateral median neuropathies at the

wrist/carpal tunnel syndrome. This condition is of mild intensity on the right side

and of borderline/mild intensity on the left side. (Px2, Px4)

On May 28, 2013 the petitioner returned to Dr. Dragisic. This doctor recorded: "MRI-c-spine confirms HNP at c-spine" and "EMG r > l CTS." Dr. Dragisic referred the petitioner to Dr. Angelopoulos for pain treatment (Px5a, Px5b), and restricted her to no lifting of anything over five pounds and no bending or stooping. The petitioner's job duties were discussed and it was determined that she could try the cashier position now that her dominant right arm was no longer in a sling. (Px2)

The petitioner testified that she returned to work with a note from the doctor and gave it to Ms. Katherine.

In Dr. Dragisic's medical records, there is a handwritten note dated 5/28/13 in which Dr. Dragisic wrote, in pertinent part, the following: "She is medically required to have light duty work only until further notice." (Px2)

The petitioner testified that Linda Ozman, her manager, told her that before she could return to work, she needed to have a more detailed note from her doctor that listed exactly how many pounds she could lift and exactly what she can and cannot do.

Prior to May 2, 2013, the petitioner had scheduled time off work from May 31, 2013 through June 3, 2013. During that time period, the petitioner embarked on a seven-hour bus trip to Minnesota to attend her granddaughter's dance recital. The petitioner did not drive to Minnesota.

On June 5, 2013, the petitioner was allowed to return to work at the cashier position. Due to her continuing low back pain, the petitioner testified, she was unable to stand more than one hour. The petitioner testified that the pain would travel down her left leg to the knee. The toes of her left foot would start going numb. The following day, the petitioner was given the day off in order to see Dr. Angelopoulos. It was decided that the petitioner would receive an injection to her low back before Dr. Angelopoulos attended to petitioner's neck complaints.

The first injection took place on June 12, 2013. The petitioner was unable to work through June 17, 2013, after which she returned to work at the cashier position. The petitioner testified that standing at the cashier position continued to exacerbate her low back pain.

The petitioner was scheduled to undergo a second injection on June 26, 2013. That injection was cancelled as the petitioner was required to work that day.

The petitioner testified that she asked for a work accommodation. She requested the use of a stool in the cashier's booth so that she could alternate standing and sitting positions in order to relieve the pain. Her request was denied. The petitioner testified that the continuous standing caused her low back pain to increase during the work hours.

On June 26, 2013, the petitioner worked on her feet at the cashier's station all day long. The petitioner testified that her low back pain became intense. After work, the petitioner went to the emergency room at Advocate Christ Hospital. (Px6) Those records indicate that the petitioner suffered from right shoulder and arm pain as well as low back pain. She was advised to remain off of work and to see her own physicians.

The petitioner returned to Dr. Angelopoulos on July 3, 2013 and was given an epidural steroid injection in the cervical/thoracic area. She was again allowed to return to light-duty work. The petitioner testified that she did return to work on July 4, 2013, but was unable to work the whole day because she was in too much pain in her neck, right shoulder, lower back and left leg.

The petitioner testified that she tried to return to work on July 5, 2013, but was in too much pain and ended up in the Advocate Christ Hospital emergency room. The emergency room physicians noted that the petitioner had chronic back pain aggravated by her work injury. The emergency room physicians suggested that the petitioner see a neurosurgeon.

On July 8, 2013, the petitioner returned to Dr. Dragisic, who prescribed a lumbar MRI and took the petitioner off of work. (Px2)

The lumbar MRI took place on July 12, 2013. The radiologist, Amjad Safvi, M.D., offered the following impression:

1. Mild to moderate scoliosis of the lumbar spine with convexity towards the left side.
2. At L3-L4 and L4-L5 levels, subtle broad based disc bulge that abuts the thecal sac. Significance of this may be correlated clinically.
3. Comparison is made with previous MRI of lumbar spine without contrast from 05/15/2012. There is no significant change in findings. (Px2)

On July 17, 2013, the petitioner returned to Dr. Dragisic who again released the petitioner to work as a cashier only with use of a stool to sit and stand as necessary. Petitioner was also referred to orthopedic specialist, Dr. Zindrick.

On July 19, 2013, Dr. Zindrick saw the petitioner. Dr. Zindrick reviewed petitioner's MRIs and performed an examination. His diagnosis was that the petitioner suffered from lumbar and cervical degenerative disc disease aggravated by the work-related accident of May 2, 2013. Dr. Zindrick took the petitioner off of work and recommended physical therapy and medication. The petitioner began a course of physical therapy at ATI.

The petitioner returned to Dr. Zindrick on August 16, 2013. He noted that she was a little better with physical therapy. However, the pain still wakes her up at night. The petitioner was continued off work, was prescribed Norco and was advised to continue physical therapy that advanced to work conditioning.

On August 19, 2013, the petitioner underwent a §12 examination by Dr. Ghanayem. The petitioner testified that the examination took approximately eight minutes. Dr. Ghanayem opined that, based on the mechanism of injury, the petitioner sustained a muscle sprain of her neck on May 2, 2013. He deferred any opinion with regard to the petitioner's right shoulder condition. Further, Dr. Ghanayem found degenerative changes at L4-L5, L3-L4 and L2-L3. Dr. Ghanayem opined that these findings are minimal and clearly age appropriate. There is nothing compressive or traumatic. Dr. Ghanayem further opined: "With regards to her lumbar spine, all I can find today is nonorganic pain behaviors." Dr. Ghanayem opined that the petitioner required no further medical care and can return back to work at regular duty. (Rx1)

The respondent called Susan Bozek to testify. Ms. Bozek was petitioner's manager or "lead" on May 2, 2013. Ms. Bozek testified that Rx5, a photograph, represents a typical crate of oranges that is placed on the salad bar/yogurt bar. Yet, on cross-examination, Ms. Bozek testified that she did not see the tray of oranges that the petitioner lifted on May 2, 2013, and did not know how high it was stacked. Ms. Bozek did not recall which of the petitioner's arms had been placed in a sling after she returned from the employee health facility. Ms. Bozek testified that the petitioner was upset that employee health did not allow her to remain off of work. Therefore, as petitioner's manager, she allowed the petitioner to do limited work. Ms. Bozek testified that the she was unaware of petitioner's low back complaints until weeks after the May 2, 2013 incident and that she never, at any time, instructed the petitioner to restock the chip rack which the petitioner testified required her to bend and stoop while using only her left arm to perform the stock duties.

Ms. Bozek also testified several times while under oath, that the petitioner was not even at work on May 3, 2013, the date petitioner testified she was required to perform stock duties using just her left arm and hand. Ms. Bozek indicated that she was positive that the petitioner was not at work on May 3, 2013 based upon her personal knowledge.

The respondent called Terri Green as its witness. Prior to the respondent stipulating that the petitioner was at work on May 3, 2013, the date petitioner alleges that the stock duties initiated her current low back pain, Ms. Green testified. Terri Green testified that the petitioner worked the morning shift, from 6:00 a.m. to 2:30 p.m. Ms. Green testified that she did not recall seeing the petitioner on May 3, 2013.

Ms. Green testified that she worked with the petitioner on Saturday, May 4, 2013 during the morning shift, from 6:00 a.m. to 2:30 p.m. Ms. Green testified that she was able to observe the petitioner wiping down the counter tops. Ms. Green testified that the petitioner did not lift anything at work that day.

The respondent also called Rickiah Smith, another of petitioner's co-workers. Ms. Smith testified that she did not know if she worked on May 3, 2013, the date that the petitioner injured her lower back. Ms. Smith testified that she did work on Saturday, May 4, 2013 where she also observed the petitioner wiping counter tops. Ms. Smith testified that the petitioner did not lift anything on May 4, 2013. On cross-examination Ms. Smith testified that she did not begin working on May 4, 2013 until 2:30 p.m. Ms. Smith testified that she cleaned up the olives that the petitioner had spilled, but did not see the petitioner drop the jar.

The petitioner sought to bifurcate the trial to produce evidence that she was at work on May 3, 2013. The matter was continued to October 18, 2013 to close proofs. Prior to presenting more testimony, the respondent stipulated that it had presented incorrect testimony about its claim that the petitioner had not been at work on May 3, 2013 since its records confirmed that the petitioner was at work during May 3, 2013.

Dr. Zindrick, the petitioner's treating orthopedic surgeon, assessed the petitioner with cervical and lumbar degenerative disc disease aggravated by her work related injuries. Dr. Dragisic opined that the petitioner's right shoulder MRI demonstrates impingement. The petitioner remains under the care of Dr. Zindrick and Dr. Dragisic. The petitioner was referred back to Dr. Angelopoulos for a facet joint

injection into her lower back. At the time of trial, Dr. Zindrick continued to keep the petitioner off of work and referred her for an FCE.

The petitioner testified that she continues to experience pain, soreness and tingling as well as intermittent numbness in her neck, shoulder, right arm down into her hand. This continues on a daily basis. She notes weakness in her right arm. The petitioner further testified that she continues to experience pain in her low back radiating down into her left leg. She is unable to stand for long periods. Sitting for an hour causes the pain to become severe. Her condition is not improving. The petitioner wishes to continue treatment with Dr. Zindrick, Dr. Angelopoulos and Dr. Dragisic.

Conclusions of Law:

In support of his decision with regard to issue (F) "Is Petitioner's current condition of ill-being causally related to the injury?", the Arbitrator makes the following findings of fact and conclusions of law:

While lifting a basket of fruit at work on May 2, 2013, the petitioner sustained an accidental injury to her right shoulder. She reported the injury immediately and first sought treatment at the employee health unit that day.

On May 6, 2013, the petitioner returned to the employee health unit and complained to Dr. Greene of constant aching in her right shoulder. Upon examination, Dr. Greene found pain on motion over the right trapezius, pain on motion over the right scapula and pain to palpation over the right deltoid and over the right supraspinatus. He also found reduced range of motion of the neck and right shoulder.

On May 9, 2013, the petitioner underwent an MRI of her right shoulder, without contrast. The radiologist offered the following impression of MRI of petitioner' right shoulder MR images:

1. Moderate chronic and acute degenerative changes at the acromioclavicular joint could represent a primary source for pain and could contribute to impingement.
2. Mild supraspinatus tendinopathy without tearing.
3. Mild subacromial/subdeltoid bursitis.
4. Moderate acromial sloping. (Px2, Px3)

MR images of the petitioner's cervical spine that were taken on May 22, 2013 were interpreted as follows: (1) At C5-C6 level, mild bilateral foraminal stenosis due to disc osteophyte complex, and (2) At C6-C7 level, subtle broad-based disc bulge that abuts the thecal sac.

On May 23, 2013, the petitioner underwent an EMG/NCS study of her upper extremities. The physician offered the following impression of the electrodiagnostic findings:

> The above electrical study is consistent with bilateral median neuropathies at the wrist/carpal tunnel syndrome. This condition is of mild intensity on the right side and of borderline/mild intensity on the left side. (Px2, Px4)

There is a handwritten notation at the bottom of the May 22, 2013 MRI report that indicates: "EMG - Radiculopathy + CTS." (Px5a)

On May 28, 2013 the petitioner returned to Dr. Dragisic. This doctor recorded: "MRI-c-spine confirms HNP at c-spine" and "EMG r > l CTS." Dr. Dragisic referred the petitioner to Dr. Angelopoulos for pain treatment (Px5a, Px5b), and restricted her to no lifting of anything over five pounds and no bending or stooping.

On June 6, 2013, Dr. Angelopoulos evaluated the petitioner's cervical spine and found tenderness off the mid line only on the right in the trapezius, moderate diffusely, muscle spasm bilaterally in an asymmetrical distribution on the right in the trapezius, and a range of motion that was slightly restricted. He also found the Spurling maneuver was positive with reproduction of pain into the right upper extremity. Dr. Angelopoulos administered an epidural steroid injection in the cervical/thoracic area on July 3, 2013.

Dr. Zindrick noted that such injection did not benefit the petitioner.

On July 19, 2013, when the petitioner first saw Dr. Zindrick, she told him that her neck pain was 50% in her right shoulder and 50% with numbness and tingling into her right hand. She stated that her symptoms were worse with any prolonged positioning standing (sic) for prolonged periods of time and that neck rotation right and left and extension cause pain. She also stated that she is best with icing and limiting her activities. Upon examination of her cervical spine, Dr. Zindrick found that her range of motion was full with pain at extremes of rotation bilaterally and extension. Flexion is full and non-painful. Biceps, triceps, brachioradialis reflexes are symmetrical +1. He found negative Werdig-Hoffman. Dr. Zindrick also found the petitioner's grip strength, biceps, triceps, wrist extension, deltoid and finger abduction to be 5/5 bilaterally and sensation to be intact throughout her upper extremities bilaterally to pinprick and light touch. Dr. Zindrick opined that Ms. Retcofsky had cervical (and lumbar) degenerative disc disease that was aggravated by the work-related accident of May 2, 2013.

The petitioner had been off of work at that point since July 6, 2013 and continued off throughout the course of the hearing.

On August 16, 2013, when the petitioner returned to Dr. Zindrick, she told him that 10% of her pain emanated from her upper body. She advised the doctor that she had two injections in her back and none in her neck. Yet, Dr. Angelopoulos' records document that she received a cervical epidural steroid injection on July 3, 2013. Upon examination, Dr. Zindick found that the petitioner demonstrated clinical findings with regard to her cervical spine that were similar to those found at last appointment.

On August 19, 2013, at the request of the respondent and pursuant to Section 12 of the Act, the petitioner submitted to an examination by Dr. Ghanayem. Dr. Ghanayem recorded that the petitioner told him she was lifting a 20-pound metal basket of fruit and was putting it into a display that was just above shoulder level. The basket began to tilt and the fruit rolled all over the place when she hurt her right shoulder girdle and neck. She continues to have ongoing pain in that region. She has no radicular pain into the arm, but complains of numbness in her fingertips. Upon examination of the cervical spine, Dr. Ghanayem found tenderness across the base and normal cervical range of motion. Lhermitte sign and foraminal compression are both negative. Her upper extremity neurologic exam reveals break away weakness in the entire right upper extremity, including pain with shoulder stabilization, but even weakness with fine flexion. Reflexes are 2+ throughout, except for her left wrist, which is 3+. Hoffmann sign is negative. Sensation is globally diminished in her right upper extremity. After reviewing the May 22, 2013,

cervical MRI, Dr. Ghanayem noted no significant abnormalities. He further noted that there is a minor degree of cervical spondylosis, but "this is about as normal an MRI as one can see in a lady in this age group." Dr. Ghanayem found nothing compressive or traumatic on the cervical MRI. Dr. Ghanayem's impression was that the petitioner suffered a muscle sprain involving the neck. The doctor opined that she had a brief course of physical therapy, which has been adequate, and no longer needs to be in effect. Dr. Ghanayem, on this date, found the petitioner to be at maximum medical improvement and released her to return to her regular-duty work.

However, Dr. Ghanayem offered no opinion as to the petitioner's right shoulder.

On July 8, 2013, Dr. Dragisic took the petitioner completely off work. Ten days later, Dr. Dragisic released the petitioner to return to work as a cashier only if she is able to utilize a stool. Based on the petitioner's testimony, the use of the stool was to allow her the opportunity to sit or stand in order to reduce the level of low back pain. Although Dr. Dragisic assessed the petitioner with, *inter alia*, right shoulder problems, there is no evidence that he recommended the use of the stool for the petitioner's right shoulder condition.

Given Dr. Zindrick's July 19, 2013 examination findings with regard to the petitioner's right shoulder and given his impression of her overall condition, the Arbitrator finds that there is no evidence that Dr. Zindrick took the petitioner off work that day for anything related to the petitioner's right shoulder condition.

No prospective medical care, specifically for the petitioner's right shoulder, has been prescribed.

Dr. Ghanayem is a professor and an orthopedic surgeon who is affiliated with Loyola University Medical Center. Dr. Zindrick is an orthopedic surgeon who is affiliated with Hinsdale Orthopaedics. Dr. Angelopoulos is a pain specialist and doctor of osteopathic medicine. Dr. Dragisic is the petitioner's family physician and a doctor of medicine.

In this case, the Arbitrator places the most weight on the opinions of Dr. Ghanayem.

At the arbitration hearing, the petitioner testified that when she lifted the basket of fruit on May 2, 2013, she felt something "pop" in the back of her neck and shoulder on the right side. She further testified that she then experienced a shooting pain down her right arm followed by numbness and tingling and a pins and needles sensation into her right hand, which was later followed by numbness in her right hand. This account of the petitioner's symptoms is not found anywhere in the records of employee health, Dr. Dragisic or Dr. Zindrick. The petitioner did report to the respondent that she felt a "pull" in her right shoulder.

The Arbitrator, after taking into account the totality of the evidence, including the petitioner's testimony as to her symptoms immediately after lifting the fruit, which is corroborated nowhere in the medical records, the MRI results, the EMG results, the clinical examinations by the treating physicians, the clinical examination by the examining physician, her participation in a seven or eight hour bus ride, round trip, over the long weekend of May 31 through June 4, and her attendance at the Taylor Street Festival, finds that the petitioner is simply not credible with regard to her ongoing complaints. The Arbitrator finds that the petitioner's ongoing complaints are not supported by the objective findings and other evidence.

The Arbitrator relies on the opinions of Dr. Ghanayem, who, on August 19, 2013, diagnosed her with a resolved cervical sprain/strain and released her to return to full-duty work. Therefore, the Arbitrator finds that the petitioner's current condition of ill-being is not causally related to the accident of May 2, 2013.

In support of his decision with regard to issues (J) "Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?", and (L) "What temporary total disability benefits are in dispute?", the Arbitrator makes the following findings of fact and conclusions of law:

Based on his findings with regard to causation, the Arbitrator further finds that the petitioner was temporarily totally disabled as a result of the May 2, 2013 accident from May 7, 2013 through June 4, 2013; from June 26, 2013 through July 3, 2013 and from July 6, 2013 through August 19, 2013, which is the date on which Dr. Ghanayem examined the petitioner and released her to return to regular-duty work. The Arbitrator notes, based on the petitioner's low back claim in consolidated case # 13 WC 18090, that the petitioner was restricted from work from June 12, 2013 through June 16, 2013. The Arbitrator addresses the issues in case # 13 WC 18090 in a separate decision.

With respect to the medical bills, the Arbitrator notes that the parties agreed that the respondent is to pay such bills directly to the providers, pursuant to Section 8(a) and subject to Section 8.2 of the Act. Based upon the Arbitrator's findings on causation, the Arbitrator awards the medical bills of Dr. Dragisic related to the shoulder or cervical spine from May 7, 2013 through July 8, 2013, after which the petitioner was referred to Dr. Zindrick, and finds that subsequent visits between the providers were duplicative and unnecessary. The Arbitrator also awards the medical bills of Dr. Angelopoulos for the cervical spine treatment from June 6, 2013 through July 16, 2013, and finds that the services of June 12, 2013 are unrelated. The Arbitrator awards medical bills for Suburban Pain Care Center, denies the medical bills of Advocate Christ Medical Center as unrelated to the cervical spine or shoulder, awards the medical bills of Hinsdale Orthopaedics from July 19, 2013, with the exception of the lumbar x-rays, and awards the services rendered by Dr. Zindrick on August 16, 2013. The Arbitrator finally awards the medical bills of ATI physical therapy, which are related to the cervical spine only, for dates of service July 25, 2013 through August 19, 2013.

All other issues, including prospective medical care, are moot.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

RICHARD MARSH,

Petitioner,

15IWCC0073

vs.

NO: 10WC39380

AT&T,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, notice, maintenance benefits, 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 May 14, 2013 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: JAN 2 8 2015
O1/13/15
RWW/rm
046

Ruth W. White

Charles J. DeVriendt

Daniel R. Donohoo

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MARSH, RICHARD
Employee/Petitioner

Case# **10WC039380**

09WC052062

AT&T
Employer/Respondent

15IWCC0073

On 5/14/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

1358 TARADASH LAW OFFICE
908 S ST ROUTE 31
McHENRY, IL 60050

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

15IWCC0073

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

Richard Marsh
Employee/Petitioner

v.

AT&T
Employer/Respondent

Case # **10** WC **39380**

Consolidated cases: **09** WC **52062**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Barbara N. Flores**, Arbitrator of the Commission, in the city of **Chicago**, on **March 11, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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 **Permanent Total Disability pursuant to Section 8(f) of Wage Differential pursuant to Section 8(d)(1)**

FINDINGS

On **December 24, 2008**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$18,995.80 (worked 14 weeks)**; the average weekly wage was **$1,258.00**. *See* AX1.

On the date of accident, Petitioner was **53** years of age, *married* with **no** dependent children.

Petitioner *has* received all reasonable and necessary medical services as explained *infra*.

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

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$10,000.00** for other benefits, for a total credit of **$10,000.00**.

Respondent is entitled to a credit for medical bills payments as reflected in the parties' exhibits as agreed by the parties under Section 8(j) of the Act. *See* AX1.

ORDER

As explained in the Arbitration Decision Addendum, the Arbitrator finds that Petitioner did not sustain an accident arising out of and in the course of his employment and that Petitioner failed to provide proper notice of such an accident. Thus, Petitioner's claim for compensation and benefits is denied.

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

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

Signature of Arbitrator

May 10, 2013
Date

MAY 14 2013

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION *ADDENDUM*

Richard Marsh
Employee/Petitioner

v.

AT&T
Employer/Respondent

Case # **10** WC **39380**

Consolidated cases: **09** WC **52062**

FINDINGS OF FACT

A consolidated hearing was held in both of Petitioner's above-captioned cases. The issues in dispute in this case are whether Petitioner sustained a compensable accident to the right shoulder on December 24, 2008, whether Petitioner gave proper notice of his claimed accident, causal connection between his claimed current right shoulder condition of ill-being and the claimed accident on December 24, 2008, whether Petitioner is entitled to the claimed medical, temporary total disability and maintenance benefits, and the nature and extent of Petitioner's injuries, including whether he is entitled to permanent total disability benefits, wage differential benefits or permanent partial disability benefits. Arbitrator's Exhibit ("AX") 2; Arbitration Hearing Transcript ("Tr. at pages") 1-9, 129. The parties have stipulated to all other issues. *Id.*

Background

Petitioner testified that he was employed by Respondent from 1988 through December 12, 2008 as a customer systems technician. Tr. at 15-16, 67-68. Petitioner became a cable splicing technician in September of 2008 because his old position was eliminated and contracted out. Tr. at 19-20. His duties included cutting, placing, and terminating single or multiple pairs of cable wires using tools ranging from a pair of utility scissors to a 40 inch cutter, wrenches, screwdrivers, hammers, single hand or hydraulic crimpers, and a 28 foot fiberglass extension ladder. Tr. at 17-18. Petitioner testified that he carried the ladder from his truck to the work location on his shoulder and estimated that the ladder weighed up to 100 pounds. Tr. at 18-19. He also testified that the cable splicer position additionally required handling and moving heavier cables and working in a manhole which required use of a sledgehammer. Tr. at 20-21. Petitioner is right-hand dominant. Tr. at 40.

Prior Medical Treatment

Petitioner testified that he underwent various surgeries while employed with Respondent. Tr. at 22-23; *see also* PX1, PX8, PX9, PX40-PX43. Petitioner had left knee surgery in 2000 and 2006 with Dr. Niccolai. Tr. at 21-22, 46, 52-53. Petitioner testified that he was eventually released to full duty work after his 2006 left knee surgery. Tr. at 53. He had a lumbar discectomy with Dr. Robbins in July 2000. Tr. at 21. He had a left rotator cuff repair with Dr. Nemickas in January of 2005. Tr. at 21, 46, 51-52. Petitioner testified that he was eventually released to full duty work. Tr. at 52. He had a left carpal tunnel release with Dr. Nemickas in May of 2006. Tr. at 22, 47, 52. Petitioner also had a right carpal tunnel release in July of 2006 with Dr. Nemickas. Tr. at 22, 47. Petitioner testified that he returned to full duty work at some point after this surgery. Tr. at 23, 52. He also testified that his right wrist was good when he returned to full duty work and that he continued to work for Respondent without any injury to the right wrist until December 12, 2008. Tr. at 23-24. Petitioner confirmed this testimony on cross-examination. Tr. at 54.

Thereafter, Petitioner has a cervical fusion on January 28, 2008 with Dr. Citow. Tr. at 22. Petitioner testified

that he was eventually released to full duty work. Tr. at 52-53. Then on March 17, 2008, he had a lumbar fusion with Dr. Citow. Tr. at 22, 47. Petitioner testified that he was eventually released to full duty work. Tr. at 53.

On cross-examination, Petitioner testified that he did not know whether he was released to return to work in May of 2006 after his 2006 left knee surgery. Tr. at 47. He could not answer whether he worked for Respondent between December 12, 2004 and January 19, 2005. Tr. at 45-46. He could not answer whether he was released to return to work on June 16, 2005 after his left shoulder surgery. Tr. at 46. Petitioner did testify that he was placed off work while recovering from both of his carpal tunnel surgeries. Tr. at 47. He further testified that he could not recall the dates during which he received treatment for his low back or when he was released to full duty work. Tr. at 47-48.

After a discussion between the parties' counsel, the parties stipulated that Petitioner was off work related to prior injuries beginning on January 20, 2005 through June 17, 2005, January 11, 2006 through May 26, 2006, and November 1, 2006 through June 26, 2007. Tr. at 49-51. Then on cross-examination, Petitioner testified that from September 15, 2008 through December 12, 2008 he worked full duty without any restrictions. Tr. at 53-54. Additionally, the Arbitrator takes judicial notice of the Commission's own records, which reflect prior cases filed by Petitioner and decisions issued by the Commission in which it made findings of fact and conclusions of law as follows:

(1) *Richard M. Marsh v. SBC*, Case No. 04 WC 58595 after which a review was filed with the Commission and it issued a decision in 08 IWCC 1121 (September 29, 2008). This claim involved an alleged cervical spine injury and addressed medical treatment including other body parts.
(2) *Richard M. Marsh v. SBC*, Case No. 05 WC 55157[1] after which a review was filed with the Commission and it issued a decision in 11 IWCC 328 (April 1, 2011). This claim involved an alleged left knee and low back injury and addressed medical treatment including other body parts.
(3) *Richard M. Marsh v. SBC*, Case No. 05 WC 55158 after which a review was filed with the Commission and it issued a decision in 10 IWCC 337 (April 5, 2010). This claim involved an alleged bilateral carpal tunnel injury and addressed medical treatment including other body parts.

Accident – Right Hand/Wrist

Petitioner testified he was working at the Marshall Field's shopping center under construction in Chicago assigned to place and splice cable in a manhole. Tr. at 24, 54. He was supplying tools and parts from Respondent's truck to the tech in the manhole. Tr. at 24-25. Petitioner testified that he was walking to the rear of the truck to get parts and while reaching up with his right hand to the left door's edge, the wind blew and slammed the right door against the back of his right hand and wrist with great force. Tr. at 25, 54-55. Petitioner described the force with which the truck door slammed on his hand as follows: "It was a really windy day. There were gusts of 50 miles an hour that day. It was great force." Tr. at 25.

Petitioner testified that he immediately noticed pain and swelling, and a large blood bruise on the back of his hand. Tr. at 25-26. Over the following two weeks, Petitioner testified he experienced pain and stiffness although he continued to work full duty. Tr. at 26.

[1] A second review was filed with the Commission related to late payment of benefits after the initial Commission decision. *Richard M. Marsh v. SBC*, 11 IWCC 328 (June 13, 2012).

Petitioner testified that he saw his family physician, Dr. Abderholden, on December 29, 2008 at 3:15 p.m. although the medical records reflect that Petitioner saw Dr. Devaney at Orchard Medical Center. Tr. at 26, 55; PX1 at 2. The medical records reflect that he reported pain in the top of his right hand after accidentally hitting the back of his hand where an IV had been placed in the recent past. PX1 at 2. Petitioner reported a problem with the vein blowing up when it was hit. *Id.* Petitioner was diagnosed with minor superficial thrombophlebitis on the back of the hand and instructed to return as needed. PX1 at 5. Petitioner testified that he was released to light duty work on December 29, 2008, but no light duty work release is noted in the Orchard Medical Center's records. Tr. at 26-27; PX1.

On cross-examination, Petitioner testified that he scheduled this appointment approximately one week before Christmas. Tr. at 55. He could not recall whether he did anything else on December 29, 2008 including testifying before an Illinois Workers' Compensation Commission Arbitrator in Waukegan with respect to a claim for bilateral carpal tunnel syndrome. Tr. at 55-57. After a discussion between the parties' counsel, the parties stipulated that Petitioner did testify at the Commission on December 29, 2008[2]. Tr. at 58.

Petitioner acknowledged that he testified in a hearing on some date regarding his bilateral carpal tunnel syndrome only and regarding what he noticed about his hands. Tr. at 60. Petitioner recalled testifying that "the carpal tunnel was corrected." Tr. at 60-61. He also recalled testifying that he had "no problems" related to the carpal tunnel. Tr. at 61. On further cross-examination, however, Petitioner also acknowledged testifying at the prior hearing about loss of strength in his hands, a popping or moving sensation in both wrists when he was lifting something heavy, "very, very" little numbness in his hands, and that "I usually do not get pain, unless it is something heavy or really stressful. Otherwise, if it is just, you know, normal light work, I do not have any pain." Tr. at 62-64. During further cross-examination questioning, Petitioner testified that he did not recall whether he testified that he was able to perform his duties as a cable splicer during the December 29, 2008 hearing. Tr. at 64. On redirect examination, Petitioner testified that he was told at the time to only answer questions regarding his carpal tunnel condition and injury. Tr. at 68-69.

On January 28, 2009, Petitioner requested to speak with Dr. Abderholden regarding swelling and pain in his right hand; Petitioner wanted to know if he needed to come in or see a hand specialist. PX1 at 3-4. Petitioner was referred to Dr. Havenhill at McHenry County Orthopedics. Tr. at 27; *see also* PX1 at 6-7, PX2 at 148.

On February 2, 2009, Petitioner returned to the Orchard Medical Center and saw Dr. Soifer with the same complaints as well as numbness and feeling as though a knot or cyst was forming. PX1 at 6-7. Dr. Soifer noted increased swelling and tenderness to palpation on the back of the right hand, referred Petitioner to a hand specialist, and instructed him to return as needed. *Id.*

Petitioner first saw Dr. Havenhill on February 26, 2009. PX2 at 148, 157-159, 163, 189. He reported that his right hand slammed in the door of his truck at work and that it did not really swell at that time, but he had a broken blood vessel which calmed down and formed a small cyst and shortly thereafter he began having swelling in the back of his hand which increased with activity causing a constant, dull, and achy pain at a level of 8-9/10. *Id.* Petitioner also reported worsened pain with bending, lifting, and grasping, as well as at the end of the day. *Id.* On examination, Dr. Havenhill noted diffuse swelling over the dorsum of the hand, thickness about the extensor tendons, but no obvious mass, and a small subcutaneous cyst approximately 3 x 3 mm on the dorsum of the hand that is mobile and not tender. *Id.* He diagnosed Petitioner with possible extensor tenosynovitis in the right hand and ordered an MRI. *Id.* Petitioner was released to full duty work. PX2 at 189.

[2] Case number 05 WC 055158. Tr. at 62-64.

On March 13, 2009, Petitioner returned reporting unchanged symptoms and marked swelling on the dorsum of the hand when using it in any significant way. PX2 at 149. On examination, Dr. Havenhill noted swelling along the extensor tendons distal to the extensor retinaculum, but no significant swelling proximal to the extensor retinaculum. *Id.* Dr. Havenhill reviewed Petitioner's MRI, which he noted showed both flexor and extensor tenosynovitis, most markedly involving the fourth extensor compartment. *Id.* He diagnosed Petitioner with right fourth extensor compartment tenosynovitis and recommended surgery. *Id.*

Petitioner underwent preoperative testing at the Orchard Medical Center on June 24, 2009. PX1 at 8-11. Then, Petitioner underwent his first right wrist surgery on June 25, 2009. PX2 at 206-207; PX3. Pre- and postoperatively, Dr. Havenhill diagnosed Petitioner with right wrist fourth dorsal extensor compartment tenosynovitis, and he performed a right wrist fourth dorsal extensor compartment tenosynovectomy. *Id*; *see also* Tr. at 27.

On June 26, 2009, Dr. Havenhill ordered a wrist splint and physical therapy two times per week for 4 to 6 weeks. PX2 at 188. On July 6, 2009, Petitioner returned to Dr. Havenhill postoperatively and was placed into a wrist splint. PX2 at 150. Petitioner was released to light duty work with use of a wrist splint and no use of the right hand. PX2 at 187. Petitioner underwent physical therapy at Spring Grove from July 13, 2009 through September 4, 2009. PX4.

On August 12, 2009, Petitioner saw Dr. Havenhill and reported that he was not doing as well in therapy as he had hoped; his wrist motion had not improved while his finger motion had improved, and he had no recurrence of tendinosis although he did get swelling on the dorsum of his wrist. PX2 at 151, 156. Petitioner also reported some general discomfort within the wrist. *Id.* On examination, Dr. Havenhill found no evidence of any extensor tenosynovitis. *Id.* He diagnosed Petitioner as status post right forth extensor compartment tenosynovectomy and giant cell tumor excision, and with possible chronic scapholunate ligament tear that may be the underlying cause for his tenosynovectomy that now seems to be symptomatic and causing loss of wrist motion. *Id.* Dr. Havenhill noted that Petitioner's job involved a lot of drills and it seemed reasonable that a chronic tear had developed over years which could be the cause of Petitioner's pain. *Id.* He administered a cortisone injection, recommended continued physical therapy, and scheduled a follow-up appointment in one month. *Id.* Petitioner was released to light duty work with no use of the right hand. PX2 at 185.

On September 9, 2009, Petitioner returned to Dr. Havenhill. PX2 at 152. At trial, Petitioner testified that his right hand was still painful and gave him a lot of problems. Tr. at 27. By contrast, the medical records reflect that Petitioner reported some slight discomfort and numbness and tingling in the small finger, but was otherwise doing well. PX2 at 152. After an examination, Dr. Havenhill noted that he was returning Petitioner back to full duty work and scheduled a follow-up appointment in six weeks. *Id.* He also noted that, given Petitioner's underlying arthritic wrist problem, he was likely to have continuing discomfort and if he experienced significant pain and ability impairment, only major surgery which would forever change his wrist might be a solution if another cortisone injection was ineffective. *Id.* Petitioner was released to full duty work. PX2 at 24; *see also* Tr. at 27.

On October 21, 2009, Petitioner reported a lot of swelling while working with crimping and pliers which was more tolerable and left symptomatic if he was not doing "such heavy repetitive gripping activity" which he localized to the dorsal radial aspect of the right hand. PX2 at 153. After an examination, Dr. Havenhill diagnosed Petitioner with right wrist swelling of unknown origin and indicated that Petitioner had what appeared to be a marked DISI deformity without any significant evidence of osteoarthritis or widening of the

scapholunate interval, which Dr. Havenhill questioned might be related to an underlying inflammatory arthritis. *Id.* He ordered an inflammatory panel to rule such arthritis out and scheduled Petitioner for follow-up. PX2 at 153, 181. Petitioner was released to full duty work. PX2 at 183.

On November 6, 2009, Petitioner reported having a lot of pain, flare-ups in the wrist when he did any crimping or twisting at work, and barely being able to use his wrist at the end of the day. PX2 at 154. He also reported that he had not yet seen the rheumatologist. *Id.* After an examination, Dr. Havenhill diagnosed Petitioner with right wrist swelling of unknown origin with recurrent extensor tenosynovitis. *Id.* He offered a cortisone injection which Petitioner refused, provided a wrist splint and issued work restrictions including use of a wrist splint, no lifting/pushing/pulling/gripping over 10 pounds with the right wrist, and no repetitive crimping/twisting with the right wrist. PX2 at 154, 179; *see also* Tr. at 27-28.

The medical records reflect that Petitioner called Dr. Havenhill requesting the aforementioned light duty work release. PX2 at 180. Dr. Havenhill again recommended that Petitioner see the rheumatologist before returning to see him. PX2 at 154. Petitioner testified that he began working light duty on Monday, November 9, 2009. Tr. p. 18.

In a letter addressed to "AT&T Disability" dated November 11, 2009, Dr. Havenhill recapped his treatment of Petitioner's right wrist to date, and noted that Petitioner may have an underlying inflammatory arthritis causing his complaints. PX2 at 155, 178. Dr. Havenhill noted his referral of Petitioner to a rheumatologist for further evaluation and that Petitioner's reports had been consistent about work duties exacerbated or aggravating his wrist condition. *Id.*

Petitioner underwent unrelated toe surgery with Dr. Stockey, a podiatrist, in December of 2009. Tr. at 28; *see also* PX1 at 44-45.

On February 15, 2010, Petitioner saw Dr. Vender at Hand Surgery Associates for right wrist pain. PX6 at 274-275; Tr. at 28. Petitioner reported that a truck door slammed onto the dorsal aspect of his hand and wrist, that he was diagnosed with extensor compartment tenosynovitis which was surgically treated, and continued stiffness, limited range of motion, and pain with intermittent swelling in the dorsal aspect of the wrist. PX6 at 274-275. After an examination and review of Petitioner's x-rays, Dr. Vender diagnosed Petitioner with ligament instability in the right wrist and status post right wrist extensor synovectomy. *Id.* Dr. Vender commented that Petitioner's right wrist complaints were consistent with Petitioner's reports of a right wrist injury and subsequent surgery. *Id.* He further noted that a good portion of Petitioner's complaints and examination findings were related to pathology in the wrist, but that it was also possible that the problems came from outside the wrist given Petitioner's history of extensor tenosynovitis and subsequent surgery. *Id.* Dr. Vender recommended wrist arthroscopy, noted that Petitioner was still under the care of his prior treating physician, and instructed Petitioner to return as needed. *Id.* Dr. Vender did not impose work restrictions because he did not know if Petitioner would continue to treat with him or return to his prior treating physician. PX23 at 706.

On March 1, 2010, Dr. Vender noted that Petitioner's main problem appeared to be ligament instability in the right wrist and he recommended surgery including possible scaphoid excision with a partial wrist fusion utilizing a bone graft vs. a proximal row carpectomy involving removal of the scaphoid, lunate and trapezium bones as the most definitive treatment for Petitioner's condition. PX6 at 276. Dr. Vender placed Petitioner on light duty work with use of the splint and no lifting/pushing/pulling over 10 pounds. *Id.*; Tr. at 28-29.

On April 6, 2010, Petitioner testified that his supervisor, Mr. Banker, informed him that there was no more light duty work available. Tr. at 29. This was the last day that Petitioner physically worked for Respondent. Tr. at 29.

Section 12 Examiner – Dr. Carroll

Dr. Carroll submitted to a deposition on January 26, 2011 during which he was questioned about his independent medical evaluation of Petitioner's right wrist and hand at Respondent's request, his opinions regarding Petitioner's condition of ill being and its relation, if any, to Petitioner's accident at work on December 12, 2008. RX1. Dr. Carroll authored a report after his examination of Petitioner on May 3, 2010. RX1 (Dep. Exh. 2).

At the time of Petitioner's evaluation on May 3, 2010, Petitioner reported difficulty with his right hand and wrist as of December 12, 2008 when "he was closing a door of a work truck[…, which he closed] on the dorsum and center portion of the right hand. He had swelling and apparently a broken blood vessel." RX1 (Dep. Exh. 2). After an examination and review of various treating medical records, Dr. Carroll opined that Petitioner had received appropriate care for a contusion of the dorsum of the right hand, that the tenolysis was appropriate but unrelated to his injury at work, that Petitioner reached maximum medical improvement approximately six months after his surgery of the right hand, and that Petitioner needed no restrictions as a result. *Id.*, RX1 at 12-14. At his deposition, Dr. Carroll clarified that "the need for care for the tenolysis, the contusion and the tenosynovectomy performed by Dr. Havenhill was caused by the injury in question, required treatment and did improve." RX1 at 13 (emphasis added).

Dr. Carroll also opined that Petitioner had evidence of scapholunate instability and that the treatment by Dr. Vender was appropriate and might require reconstructive surgery later on, however, this condition was not related to Petitioner's injury at work and that he would require further information about the weight of the door, pictures, and perhaps other documentation to determine whether there was any relationship between the wrist instability and the injury at work. *Id.*; RX1 at 12-15. At his deposition, Dr. Carroll expounded on his opinion and testified that generally one would expect to see scapholunate instability as a result of a compressive force/significant trauma which would drive the wrist bones apart and rip the ligaments, which was not present in Petitioner's case. RX1 at 14-16.

On cross examination, Dr. Carroll further testified that the type of force necessary to cause wrist instability in the manner described by Petitioner would require a "very, very, very heavy door, I am not sure, something like an 18-wheeler truck door type of thing was swung in a 40, 50-mile an hour wind and the wrist got caught in the door came across the wrist and crushed the wrist pretty hard and caught the wrist in the door, that might cause it. But it wouldn't be a door just struck a glancing blow and caused it. So it would be a very significant force with a very heavy door, hence the questions that I asked that might or could cause that. I've not heard data to suggest that's the case to date." RX1 at 22-23. He acknowledged that the velocity at which the door swung would affect the amount of force necessary to cause Petitioner's wrist instability. RX1 at 23-24. Dr. Carroll also testified that he was not aware that Dr. Vender performed surgery on Petitioner on August 31, 2010. RX1 at 26-27.

Continued Medical Treatment

On July 12, 2010, Petitioner returned to Dr. Vender for examination of the bilateral upper extremities with the right side being more symptomatic, pain radiating proximally, and developing symptoms on the left side. PX6

at 277. He kept Petitioner on light duty work with use of the splint and no lifting/pushing/pulling over 10 pounds and instructed him to return as needed. *Id.*

In a letter dated July 22, 2010 addressed to Petitioner's counsel, Dr. Vender noted his review of certain of Petitioner's medical and physical therapy records and Dr. Carroll's independent medical evaluation dated May 3, 2010. PX6 at 295-297. Dr. Vender indicated as part of his opinion on causation that there "are no indications of a pre-existing wrist condition[,]" but he ultimately opined that it was not unreasonable to assume that Petitioner could have undergone an injury to the tendons adjacent to the ligaments in question resulting in the injury that necessitated the surgical intervention performed by Dr. Havenhill in the surgical intervention recommended by Dr. Vender. *Id.*

Petitioner underwent his second right wrist surgery with Dr. Vender on August 31, 2010. PX6(a) at 319-320; Tr. at 29. Preoperatively, Dr. Vender diagnosed Petitioner with right wrist pain and carpal instability. *Id.* Dr. Vender performed right wrist arthroscopic debridement. *Id.* Postoperatively, he diagnosed Petitioner with right wrist pain and carpal instability plus scaphoid chondromalacia, triangular fibrocartilage complex (TFCC) tear, and ulnar impaction. *Id.*

Petitioner testified that at his first physical therapy evaluation on September 3, 2010, the "physical therapist noticed that I was not moving my right shoulder properly." Tr. at 29-30. Petitioner also testified that he experienced pain and that he could not reach above his head using his right shoulder. Tr. at 29-30. The Arbitrator notes that Petitioner did not explain how he knew what the physical therapist noticed about him. A physical therapy note of the same date reflects "Pt placing (R) shoulder in awkward positions to perform functional tasks." PX7 at 325.

Petitioner returned postoperatively on September 9, 2010, at which time Dr. Vender discussed Petitioner's surgical findings, recommended a proximal row carpectomy, and ordered occupational therapy. PX6 at 278; *also* Tr. at 29. He also noted that given Petitioner's "underlying wrist arthritic problem, he is likely to have some continuing discomfort." *Id.* Petitioner returned on September 16, 2010 and was restricted to sedentary work only. *Id.*

On September 28, 2010, Petitioner underwent his third right wrist surgery with Dr. Vender. PX6(b) at 321-322; Tr. at 31. Pre-and postoperatively, Dr. Vender diagnosed Petitioner with right wrist derangement with carpal instability, arthritis, and extensor lower tenosynovitis. *Id.* He performed a right wrist proximal row carpectomy and right wrist extensors tenolysis and tenosynovectomy of the second, third, fourth, and fifth compartment. *Id.*

Petitioner returned postoperatively on September 30, 2010, at which point Dr. Vender placed Petitioner in a short arm cast, discussed surgical intervention for symptomatology on the left side, and placed Petitioner off work. PX6 at 280. Petitioner continued to follow up with Dr. Vender postoperatively through December 27, 2010. PX6 at 281-284. During that time, Dr. Vender restricted Petitioner to light duty work only until his full duty release on December 27, 2010. *Id.*; *see also* Tr. at 32. Petitioner also underwent physical therapy as ordered by Dr. Vender. PX6 at 291-292.

Thereafter, Petitioner underwent left wrist surgery on January 4, 2011 for an unrelated medical condition. PX6(c) at 323-324; Tr. at 32-33.

Dr. Vender

Dr. Vender submitted to a deposition on November 22, 2010 during which he was questioned about his treatment of Petitioner's right wrist and his opinions regarding Petitioner's condition of ill being and its relation, if any, to Petitioner's accident at work on December 12, 2008. PX23. Dr. Vender opined that his diagnoses of Petitioner were consistent with Petitioner's reported mechanism of injury because the localization of Petitioner's wrist abnormality was in the area of trauma identified by himself and Dr. Havenhill, and because Petitioner's TFCC tear and ligament injury was consistent with trauma as opposed to a degenerative condition. *Id.*, at 707-709, 720-721.

Dr. Vender testified that he was unable, however, to comment on Dr. Havenhill's chronic scapholunate ligament tear diagnosis. *Id.*, at 712-714. Dr. Vender could not tell the age of Petitioner's x-ray findings from Petitioner's first visit to him in February such that he could render an opinion whether Petitioner's ligament tear resulted from a chronic condition or acute injury. *Id.* He added that for Dr. Havenhill to describe that Petitioner's scapholunate ligament tear as chronic "... he'd have to have some kind of visible arthritis [in Petitioner's x-ray findings] to say that it was chronic. Otherwise, again he is not in a position necessarily to say that those x-ray findings acute [sic] or chronic." *Id.* Dr. Vender was not aware of Petitioner having any symptoms attributable to scapholunate instability prior to his injury at work. *Id.*, at 722.

Dr. Vender also testified that when he first saw Petitioner, he did not describe how he was standing at the time of the accident, the position of his hand in the door, whether the door was a sliding or swinging door, and that he did not recall whether he had any treating medical record of Petitioner's treatment from December of 2008 until Petitioner began treating with Dr. Havenhill. *Id.*, at 724-725. Dr. Vender further testified that force is a factor affecting whether the type of injury sustained by a patient in a traumatic accident, but that force was difficult to quantify. *Id.*, at 722-723.

The Arbitrator notes that Dr. Vender was not questioned about and he did not testify regarding Petitioner's permanent disability, if any, or permanent restrictions.

Right Shoulder Treatment

Dr. Abderholden referred Petitioner to Dr. Nemickas for a right shoulder evaluation. PX8 at 333-334. Petitioner saw Dr. Nemickas for the first time on January 17, 2011. *Id.* Petitioner reported "right shoulder pain and discomfort times many year's duration." *Id.* He also reported that the right shoulder pain and discomfort had progressed while on the job and that he carried a two-section ladder on his right shoulder, which he was usually able to manage with activity modification. *Id.* Petitioner further reported undergoing treatment for bilateral wrist injuries and that in the process of recovery he favored his right shoulder with worsening pain and discomfort which impeded his activities of daily living, caused difficulty sleeping, and trouble getting through the course of the day. *Id.* On examination, Petitioner had hypertrophy at the AC joint, positive impingement, and decreased rotator cuff strength in the scapular plane at 3+/5. *Id.* Additionally, Petitioner was not tender to palpation, had negative crossover/provocative biceps/SLAP/labral tests, focal he intact CMS without deficits, and no tenderness in the arm/forearm/hand compartments. *Id.*

Petitioner underwent right shoulder x-rays which Dr. Nemickas noted showed evidence of AC joint hypertrophic, type II acromion, and no acute fracture/dislocation. *Id.* He diagnosed Petitioner with right shoulder presumed occult internal derangement, ordered a right shoulder MRI, and did not impose any additional medical restrictions given that Petitioner's left wrist work restrictions exceeded what he would have

imposed. *Id.*

On January 26, 2011, Petitioner returned to Dr. Nemickas reporting continued and unchanged right shoulder pain and discomfort. PX8 at 336-337. Dr. Nemickas reviewed Petitioner's January 21, 2011 MRI and diagnosed him with a right shoulder rotator cuff tear with concomitant SLAP tear and bicipital rupture. *Id.*; PX8(a) at 509-509. The interpreting radiologist noted that Petitioner's right shoulder MRI showed the following: (1) a small to moderate joint effusion with significant degenerative changes acromioclavicular joint; and (2) full-thickness tear supraspinatus tendon and bicipital tendon with some retraction of each structure and a sprain of the intact subscapularis tendon. PX8(a) at 508-509. Dr. Nemickas noted that Petitioner understood that "his years of service in carrying the 100-pound sectional ladder have resulted in an internal derangement of his shoulder in which he has ruptured both his bicipital tendon as well as his rotator cuff." PX8 at 336-337. Dr. Nemickas recommended surgery. *Id.*

On January 28, 2011, Petitioner underwent preoperative testing at Orchard Medical Center. PX1 at 46-51, 53-55.

On January 31, 2011, Dr. Vender released Petitioner from care for both hands. Tr. at 33. Petitioner testified that he was placed on permanent work restrictions. Tr. at 33-34.

On February 9, 2011, Petitioner underwent right shoulder surgery with Dr. Nemickas. PX9 at 511-512; Tr. at 34. Preoperatively, Dr. Nemickas diagnosed Petitioner with right shoulder internal derangement. *Id.* He performed the following procedures: (1) examination under anesthesia, diagnostic arthroscopy, and debridement; (2) biceps tenodesis; (3) rotator cuff repair; (4) arthroscopic subacromial decompression; and (5) arthroscopic Mumford. *Id.* Postoperatively, Dr. Nemickas diagnosed Petitioner with chronic bicipital tenosynovitis, extensive synovitis, rotator cuff tear, subacromial impingement, and advanced acromioclavicular joint degenerative joint disease. *Id.* Petitioner testified that he was placed off work. Tr. at 34-35; *see also* PX9.

Petitioner testified that he separated from Respondent's employment on February 11, 2011. Tr. at 35, 66. On cross-examination, Petitioner testified that he remained under active medical care for that his right shoulder and left hand at this time. Tr. at 66.

The medical records reflect Petitioner saw Dr. Nemickas postoperatively on February 21, 2011. PX8 at 339. Dr. Nemickas ordered physical therapy once a week for four weeks, use of his arm sling, and to return for follow up in one month. *Id.* Petitioner returned on March 21, 2011 at which time Dr. Nemickas noted that Petitioner had given consideration to returning to work and that he did "not believe that [Petitioner] will recover to the point that he will be able to do a U.S. Department medium-heavy to heavy labor particularly overhead work and carrying above aforementioned loads [i.e., 100-pound two-piece ladder] across the shoulder girdle at this time...." *Id.* Dr. Nemickas kept Petitioner off work.

Petitioner was referred for a functional capacity evaluation, which he underwent on March 16, 2012. Tr. at 35; PX10 at 620-636. The test results and Petitioner's efforts were deemed to be valid. *Id.*

The physical therapist noted that the FCE referral was for Petitioner's right shoulder arthroscopy in February of 2011 however Petitioner stated "that is not his limiting factor. He feels he is undergoing this test due to right wrist and hand pain, but is limited with several parts of his body." PX10 at 622. Petitioner reported undergoin 15 surgeries over the prior 10 years for body parts not affected by either accident at issue in either of Petitioner claims (i.e., left knee, toe, left shoulder, neck, left hand, etc.). *Id.* Petitioner reiterated that "[h]e want it noted

his right shoulder arthroscopy was the last surgery performed but he feels that bilateral wrists, back, and left knee limit his activities." PX10 at 634. Petitioner reported that he did not think that he was capable of doing any jobs. PX10 at 635.

Ultimately, the physical therapist determined that Petitioner had "multiple restrictions and limiting factors that will make it difficult to find a suitable job in the future. He is in the sedentary category but is unable to sit or stand for prolonged periods, as well as he is unable to perform fine manipulation or grip." PX10 at 620-621, 635-636.

On May 2, 2011, Petitioner followed up with Dr. Nemickas who ordered additional physical therapy, kept him off work, and scheduled a follow up in approximately 6 to 8 weeks. PX8 at 342.

Approximately 8 months later on January 4, 2012, Petitioner returned to Dr. Nemickas reporting the ability to perform routine activities of daily living without appreciable difficulty, some intermittent soreness and discomfort anterolaterally with mild sleep disturbances at times which were fairly limited with modification and associative use of modalities. PX8 at 343. Dr. Nemickas commented that Petitioner was "not going to be able to return to work as a lineman for Ameritech as he will no longer be able to safely ascend and descend ladders or scaffolds and poles nor be able to tolerate carrying the bi-fold ladder along the top of his shoulder girdle due to the underlying concomitant structural changes. Particularly, the degenerative change to the region and the associative tearing and repaired tissues." *Id.* He recommended vocational retraining and rehabilitation without exertion across the shoulder or exposure to eccentric loads associated with pulling the wire. *Id.* Petitioner was instructed to return as needed and discharged from treatment. *Id.*

Section 12 Report – Dr. Bach

Petitioner submitted to an independent medical evaluation with Dr. Bach at Respondent's request on June 18, 2012. PX36. Dr. Bach noted that Petitioner refused to answer any of his questions and he thought of the independent medical evaluation and delays related to the independent medical evaluation as "a game." *Id.* Moreover, Dr. Bach noted that Petitioner refused to answer any questions related to Petitioner's job duties or even his job title. *Id.* After his review of a summary of Petitioner's medical treatment provided by Respondent's counsel, various medical records, interviewing Petitioner to little avail, and a physical examination, he opined that Petitioner's work duties caused his right shoulder condition. *Id.*

Dr. Nemickas

Dr. Nemickas submitted to a deposition on March 23, 2013 during which he was questioned about his treatment of Petitioner's right shoulder, his opinions regarding Petitioner's condition of ill being and its relation, if any, to Petitioner's work activities, and Petitioner's ability to work. PX35. In response to a lengthy hypothetical question and follow up questioning, Dr. Nemickas ultimately opined that Petitioner's right shoulder internal derangement condition was causally related to his repetitive activities while working for Respondent over 22 years including lifting, carrying, walking with, and balancing a 100-pound ladder while placed over the right shoulder. PX35 at 778-783.

On cross examination, Dr. Nemickas acknowledged that on the date of Petitioner's initial visit he was not aware how long Petitioner had worked for Respondent, whether Petitioner was still working for Respondent, the weight of Petitioner's ladder, or how often he carried the ladder. *Id.*, at 784-790. Dr. Nemickas also testified that Petitioner felt that his right shoulder condition had developed from chronic use at work. *Id.*, at 790.

Dr. Nemickas also testified that that Petitioner reported a date of onset for his right shoulder condition of September 3, 2010 without explanation. *Id.*, at 785-786. The Arbitrator notes that this is the date on which Petitioner testified that a physical therapist noticed that he was not properly using his right shoulder.

Dr. Nemickas also testified that regarding his postoperative diagnoses. PX35. He acknowledged that Petitioner's chronic bicipital tenosynovitis as diagnosed by him postoperatively could have resulted from degeneration or an acute injury or some type of repetitive use involving force, whether at work or elsewhere. *Id.*, at 790-791. He testified that extensive synovitis could be part of a degenerative condition. *Id.*, at 791-792.

Dr. Nemickas also acknowledged that the usual and customary return to work after surgery would have been 6 to 8 weeks after Petitioner's May of 2011 surgery. *Id.*, at 795-796. Dr. Nemickas did not see Petitioner again until January 4, 2012, so he was unable to opine on Petitioner's functional capability regarding the right shoulder at that time. *Id.* He further testified that he did not know whether Petitioner was working through January of 2012 and he declined to opine on whether Petitioner could return to work as a splicer because he had not seen Petitioner's splicer job description. *Id.*, at 797-799.

Medical Bills

Petitioner submitted a variety of bills for medical treatment for which he claims Respondent is liable related to reasonable and necessary treatment for his right hand/wrist and right shoulder. Petitioner testified that, other than Dr. Havenhill's first bill, his medical bills from December 29, 2008 through September 3, 2010 relating to his right hand were not paid by the workers' compensation insurance; some bills were paid by his group health insurance and some were paid by him out of pocket. Tr. at 41-42.

Sedgwick CMS authorized various services including a right hand MRI, Petitioner's surgery with Dr. Havenhill. occupational therapy for 8 visits, and a wrist splint. PX2 at 174-175, 177, 197.

Additional Information

Petitioner testified that he is a "hunting and poke" computer user. Tr. at 40. He testified that he is a "sport man" and generally uses the computer for e-mails and online purchases. *Id.* Petitioner is not currently employed. Tr. at 41.

Regarding his right hand and wrist, Petitioner testified that he has pain, swelling, and cramping in the fingers with any repetition in the right hand and wrist. Tr. at 35-36. Petitioner described difficulty with repetition stemming from household activity including dishes, wiping off counters, sweeping, vacuuming, tightening buttons, tying/untying shoelaces, knotting, bathing, and brushing his teeth. Tr. at 36-37. He also testified that he has a hard time with his fingers if he writes or prints for too long, he has a big problem with paging through newspapers, magazines, or books, he has difficulty picking up and grasping small objects like pens or papers, and if he adds any weight whatsoever to his right hand with tools, a hammer, a screwdriver, or a wrench, to use those tools "it makes it worse." Tr. at 37-40.

On cross-examination, Petitioner testified that he is an outdoor sportsman who liked to fish and hunt, but that h had not fished since his accident and that he only engages in limited bird and small game hunting using a 12gauge shotgun. Tr. at 66-67. To use the shotgun, Petitioner uses his right shoulder and also uses his right index finger to pull the trigger. Tr. at 67.

The Arbitrator notes that Petitioner did not testify about any current condition of ill-being or symptomatology related to his right shoulder.

Vocational Rehabilitation – Mr. Belmonte

Joseph Belmonte ("Mr. Belmonte") testified that he is employed by Vocamotive and that he is a certified rehabilitation counselor. Tr. at 71-74. At Petitioner's counsel's request, Mr. Belmonte prepared a vocational evaluation report dated January 30, 2012. Tr. at 74; PX37. Mr. Belmonte testified that he did not have a lot of detailed information about Petitioner's residual physical capacity to have a real understanding of what Petitioner could or could not do. Tr. at 81-82, 114. Mr. Belmonte's report reflects that "it should not be assumed that [Petitioner] is employable at any level.... [and that] a comprehensive vocational evaluation is necessary before any determination along those lines can be made or assumed." PX37 at 828-829.

At Petitioner's counsel's request, Mr. Belmonte authored a supplemental evaluation report dated April 10, 2012. Tr. at 82, 116; PX38. Mr. Belmonte reviewed Petitioner's functional capacity evaluation and found it remarkable that Petitioner did not complete certain portions of the test including dynamical lifting or carrying because the evaluator considered Petitioner's lifting and carrying mechanics to be unsafe. Tr. at 84-86. Mr. Belmonte also noted that the FCE evaluator modified lifting protocol for Petitioner's test and that Petitioner's performance was slow or limited with regard to certain testing activities. Tr. at 86-87.

Ultimately, Mr. Belmonte determined that Petitioner had lost access to his usual and customary job/line of occupation as well as the jobs/occupations that he historically performed, did not currently have any viable, stable labor market offering gainful employment available to him, and that Petitioner's physical restrictions did not facilitate a match with any reasonably well-known occupation including any unskilled or low skilled positions such that vocational rehabilitation was not viable. PX38.

At trial, Mr. Belmonte testified that there was nothing outside of his original or supplemental reports that he considered in reaching his conclusions that he failed to note in either report. Tr. at 91. On cross-examination, however, Mr. Belmonte testified that he performed a transferable skills analysis based on his knowledge, experience, and the information provided to him about Petitioner, but that he did not detail how he reached his conclusion about the transferability of Petitioner's skills in his report. Tr. at 119-123.

Mr. Belmonte reviewed the vocational assessment report and labor market survey authored at Respondent's request. Tr. at 98-99; *see also* RX2-RX3. He noted that Ms. Allen referenced an independent medical evaluation report authored by a Dr. Bach which he had not seen. Tr. at 101.

Mr. Belmonte disagreed with Ms. Allen's opinion that any of the jobs identified by Ms. Allen work available to Petitioner because Petitioner's FCE results were based on a "heavily modified" evaluation "in order to gain any measurement of [Petitioner's] lifting capacity...[]" and Petitioner's limitations identified in the FCE. Tr. at 102-104. Mr. Belmonte testified that in virtually any occupation that he could think of, Petitioner would require some kind of accommodation based on Petitioner's FCE results and that "[t]he reality is there are very few, if any, jobs in the US economy that do not require use of the hands." Tr. at 104-106.

On cross-examination, Mr. Belmonte testified that an FCE is a diagnostic tool and, essentially, must be viewed in conjunction with any examining physician his review of the FCE results. Tr. at 116-17. Ultimately, one must refer to the expert medical opinion of the physician, unless he or she concurs with the FCE results, and that it is

the physician's ultimate responsibility to release a patient to return to work or not. Tr. at 117-118.

Vocational Rehabilitation – Ms. Allen

Samantha Allen ("Ms. Allen") testified that she is employed by Encore Unlimited and that she is a certified rehabilitation counselor. Tr. at 130; *see also* RX2. At Respondent's counsel's request, Ms. Allen prepared a vocational evaluation report dated November 29, 2012. Tr. at 133; RX2. Ms. Allen testified that a labor market survey was prepared at Respondent's request on September 11, 2012 by her co-worker, Alla Massat ("Ms. Massat"), which is kept in the ordinary course of her business and upon which she relied in reaching her conclusions regarding Petitioner's employability. Tr. at 133-135; RX3.

Ms. Allen testified that she utilized a program from VocRehab.com to perform a transferable skills analysis and that her report does not contain the complete list of occupations or parameters that she used and that are available for input as criteria into the VocRehab.com program because, essentially, she had to use common sense, her experience, and jobs available in the labor market to find the best match for Petitioner and retain only jobs that she felt were appropriate for Petitioner. Tr. at 137-140, 154-166, 176-177. Ms. Allen also testified that the jobs listed in the labor market survey actually existed in the job market. Tr. at 140-141.

Ms. Allen reviewed a vocational evaluation report authored by Lisa Byrne ("Ms. Byrne") dated January 30, 2013. Tr. at 141-142; PX47. Ms. Byrne ultimately determined that very few employment possibilities existed for Petitioner given his work history, testing results, achievement levels, reasoning, aptitudes, physical abilities and limitations, and results of a transferrable skills analysis. PX47.

Ms. Allen testified that she used to work with Ms. Byrne at Coventry. Tr. at 142. Ms. Allen disagreed with some of the opinions contained in Ms. Byrne's report including that there were minimal occupations in which Petitioner could engage, Petitioner could not work eight hours per day, and Petitioner had very few employment possibilities which required a highly accommodated environment. Tr. at 142-144. Ms. Allen also testified that Petitioner's Wide Range Achievement Test ("WRAT-4") results support Ms. Allen's conclusion that Petitioner is a vocational rehabilitation candidate because he has the ability to learn a new occupation and undergo on-the-job training based on his test results. Tr. at 144-145. Ms. Allen further noted that the COPS survey identified in Ms. Byrne's report is a self-directed inventory test taken by the injured worker. Tr. at 150-151.

Additionally, Ms. Allen reviewed Mr. Belmonte's reports. Tr. at 146. She disagreed with Mr. Belmonte's conclusion that Petitioner is not employable, that Petitioner is not a candidate for even the most unskilled or low skill employment (e.g., security worker, cashier, retail salesperson, etc.), and she testified that she did in fact find employment matches for Petitioner. Tr. at 146-148. Ms. Allen added that certain positions would require a reasonable accommodation for Petitioner's physical capabilities. Tr. at 148-149. On redirect examination, she testified that it was not her intention when she listed those jobs to mean that Petitioner could work in these positions without any accommodation or consideration for his specific needs. 179-180.

On cross-examination, Ms. Allen was questioned about various jobs identified in Petitioner's group exhibit 49. Tr. at 166-175. She acknowledged that there were physical requirements and these job descriptions that were outside of Petitioner's physical capabilities, but testified, essentially, that Petitioner would need reasonable accommodations to perform these jobs. *Id.* She also acknowledged that she did not know the difference between material handling, handling, and fingering noted in the Dictionary of Occupational Titles assignment clerk job description contained in the physical demands portion of the description. PX49(a) at 4. On redirect examination, Ms. Allen testified that there might be a job category in the labor market that is not specifically

called assignment clerk and that does not actually require frequent reaching, handling, or fingering. Tr. at 178.

ISSUES AND CONCLUSIONS

The Arbitrator hereby incorporates by reference the Findings of Fact delineated above and the Arbitrator's and parties' exhibits (AX2, PX1-PX25, PX34-PX44, PX47-PX49, RX1-RX3) are made a part of the Commission's file. After reviewing the evidence and due deliberation, the Arbitrator finds on the issues presented at trial as follows:

In support of the Arbitrator's decision relating to Issue (C), whether an accident occurred that arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator finds the following:

The Arbitrator finds that Petitioner failed to establish by a preponderance of credible evidence that he sustained a compensable accident resulting in an injury to the right shoulder as a result of repetitive trauma on December 24, 2008.

First, the Arbitrator addresses Petitioner's alternative arguments regarding the date of his alleged accident at work. Petitioner argues that his accident occurred on either December 24, 2008 ("the last day Petitioner worked in full duty capacity") or on September 3, 2010 ("the date Petitioner was first informed by a medical provider that his injury may be work related"). The Arbitrator takes judicial notice of the Commission's own file in this case which reflects an Application for Adjustment of Claim filed by Petitioner on October 12, 2010 alleging that he "sustained multiple injuries [to the right shoulder] while working" and which occurred on September 3, 2010. At trial, Petitioner amended his accident date to December 24, 2008. AX2.

An employee claiming that he suffered a repetitive-trauma injury may apply for benefits under the Illinois Workers' Compensation Act ("Act") and file his claim within three years after the date of accident pursuant to Section 6(d) of the Act; however he must meet the same standard of proof as an employee that suffered an injury resulting from a discrete event. *Durand v. Industrial Comm'n*, 224 Ill. 2d 53, 64, 862 N.E.2d 918 (Ill., 2006). That is, the employee must still point to a date within the statutory limitations period on which both the injury and its causal link to his work became plainly apparent to a reasonable employee—the so-called manifestation date. *Durand*, 224 Ill. 2d at 65. Additionally, parties are bound the stipulations made in the request for hearing form. *Walker v. Industrial Comm.*, 345 Ill. App. 3d 1084, 1087-88, 804 N.E.2d 135 (4th Ill. App. Dist., 2004). Thus, Petitioner must establish that he sustained a compensable injury on one date, and he elected December 24, 2008 as the claimed date of accident. The Arbitrator finds that Petitioner failed to prove that he sustained a repetitive trauma injury manifesting itself on December 24, 2008 as claimed.

At trial, Petitioner testified that he carried a ladder weighing up to 100 pounds from his truck to varied work locations on his shoulder. Petitioner did not testify at all about any right shoulder complaints in or around December of 2008 or that he had any right shoulder complaints at all until his first physical therapy evaluation on September 3, 2010 when the "physical therapist noticed that I was not moving my right shoulder properly." Petitioner testified that this was the first time that he experienced pain and could not reach above his head using his right shoulder. A physical therapy note of the same date reflects "Pt placing (R) shoulder in awkward positions to perform functional tasks." The Arbitrator declines to find that this physical therapist's notation that Petitioner's right shoulder was placed in awkward positions during a physical therapy session is tantamount to a finding that the physical therapist alerted Petitioner to the fact that he had some right shoulder condition that was causally related to his duties at work. Petitioner did not explain how he knew what the physical therapist

noticed about him on September 10, 2010 and the physical therapist did not testify at trial. Notwithstanding, the record reflects a different chain of events related to Petitioner's claimed right shoulder injury.

Petitioner reported no complaints relative to his right shoulder in any of the treating medical records until his first examination with Dr. Nemickas on January 17, 2011. At this time, approximately 4 1/2 months after the aforementioned physical therapy session, Petitioner saw Dr. Nemickas—the physician that previously treated him for unrelated conditions in the left shoulder and neck. At that visit, Petitioner reported "right shoulder pain and discomfort *times many year's [sic] duration*" (*emphasis* added). He also reported that the right shoulder pain and discomfort had progressed while on the job and that he carried a two-section ladder on his right shoulder, which he was usually able to manage with activity modification. Petitioner further reported *undergoing treatment for bilateral wrist injuries and that in the process of recovery he favored his right shoulder* with worsening pain and discomfort which impeded his activities of daily living, caused difficulty sleeping, and trouble getting through the course of the day. Petitioner treated for his claimed bilateral carpal tunnel condition from 2005 through 2006. Again, Petitioner's credibility is eroded when viewing his testimony at trial and the arguments made in support of his claim in comparison to other evidence.

Moreover, while Petitioner also testified that he was continuously employed with Respondent from 1988 through 2008, his testimony must be scrutinized in light of the record as a whole. The Arbitrator notes her finding that Petitioner's testimony at the consolidated hearing in the above-referenced cases was not credible. See Decision in 09 WC 52062. To summarize, Petitioner's testimony at trial was repeatedly inconsistent with documentary evidence and inconsistent between direct and cross examinations. The Arbitrator finds that Petitioner's testimony relating to his claimed right shoulder injury is similarly unreliable and not credible.

Petitioner conceded on cross examination that he missed time from work in the years preceding 2008 due to medical leave for other health conditions. Given Petitioner's failed memory on cross examination and after a discussion between the parties' counsel, the parties eventually stipulated that Petitioner was off work related to prior injuries beginning on January 20, 2005 through June 17, 2005 (4 ½ months), January 11, 2006 through May 26, 2006 (4 ½ months), and November 1, 2006 through June 26, 2007 (almost 8 months). An examination of the Illinois Workers' Compensation Decisions in Petitioner's prior claims confirms that Petitioner did not work full duty throughout the four years preceding December 24, 2008 due to multiple periods of lost time for his prior injuries and conditions. Even during the approximately 88 weeks from December 24, 2008 through September 3, 2010, Petitioner did not work for Respondent in any capacity for approximately 32 weeks (i.e., Petitioner was placed off work for 11 and 1/7th weeks related to the right hand injury claimed in Case No. 09 WC 52062 and he stopped physically working for Respondent on April 6, 2010).

Furthermore, Dr. Nemickas conceded that on the date of Petitioner's initial visit he was not aware how long Petitioner had worked for Respondent, whether Petitioner was still working for Respondent, the weight of Petitioner's ladder, or how often he carried the ladder. Dr. Nemickas also acknowledged that Petitioner's postoperatively diagnosed chronic bicipital tenosynovitis could have resulted from degeneration, an acute injury. or some type of repetitive use involving force, whether at work or elsewhere, and that Petitioner's extensive synovitis could be part of a degenerative condition. Given these facts and in light of Petitioner's lack of credibility, the Arbitrator is not persuaded by Dr. Nemickas' opinions regarding causal connection.

Finally, the Arbitrator notes that Petitioner did submit to an independent medical evaluation with Dr. Bach at Respondent's request on June 18, 2012 after which he opined that Petitioner's work duties caused Petitioner's right shoulder condition. The Arbitrator does not find Dr. Bach's conclusion to be persuasive and notes that it was rendered on the limited information provided to him which included an examination during which

Petitioner refused to answer any of his questions and even refused to answer any questions related to his job duties or his job title. Petitioner also referred to the independent medical evaluation process as "a game." Petitioner's obstinacy with Dr. Bach is not surprising as it was evident during trial as well. The Arbitrator is not persuaded that Dr. Bach could reach a reasonable causal connection opinion regarding a repetitive trauma shoulder injury under these circumstances.

Based on all of the foregoing, the Arbitrator finds that Petitioner failed to establish by a preponderance of credible evidence that he sustained a compensable accident resulting in an injury to the right shoulder as a result of repetitive trauma on December 24, 2008. By extension, all other issues are moot and all requested compensation and benefits are denied.

In support of the Arbitrator's decision relating to Issue (E), whether timely notice of the accident given to Respondent, the Arbitrator finds the following:

As explained in detail above, Petitioner failed to establish that a compensable accident arose out of and in the course of his employment. Thus, the issue of whether Petitioner gave timely notice of such an accident is rendered moot. Notwithstanding, the Arbitrator also finds that Petitioner failed to prove that he gave timely notice of his claimed accident occurring on December 24, 2008 to Respondent.

Notice of the accident shall give the approximate date and place of the accident, if known, and may be given orally or in writing, but not later than 45 days after the accident with some very limited exceptions. 820 ILCS 305/6(c) (West 2000). Employees who claim to have suffered repetitive trauma injuries are not exempt from meeting the statutory notice requirement. *White v. Workers' Compensation Comm'n*, 374 Ill.App.3d 907, 910-911, 873 N.E.2d 388 (4th Ill. App. Dist., 2007) (*citing Three "D" Discount Store v. Industrial Comm'n*, 198 Ill.App.3d 43, 144 Ill. Dec. 794 (1989)).

In the present case, Petitioner failed to submit any evidence whatsoever that he gave Respondent proper notice of the alleged December 24, 2008 accident within 45 days of its occurrence. The Arbitrator notes that Petitioner filed his Application for Adjustment of Claim within 45 days of the "alternative" September 3, 2010 accident date, however as explained in detail above, the medical records reflect that Petitioner reported that he had symptomatology in the right shoulder for years prior to even December 24, 2008 during his treatment for the previously claimed bilateral carpal tunnel condition. Then, Petitioner reported no complaints relative to his right shoulder whatsoever for a large gap in time until his first examination with Dr. Nemickas on January 17, 2011 even though he filed an Application for Adjustment of Claim related to the right shoulder in October of 2010.

Based on all of the foregoing, the Arbitrator finds that Petitioner failed to establish by a preponderance of credible evidence that he gave proper notice of his claimed accident. By extension, all other issues are moot and all requested compensation and benefits are denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

RICHARD MARSH,

Petitioner,

15IWCC0074

vs.

NO: 09WC52062

AT&T,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of medical expenses, 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 May 14, 2013 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: JAN 2 8 2015
O1/13/15
RWW/rm
046

Ruth W. White

Charles J. DeVriendt

Daniel R. Donohoo

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

15IWCC0074

MARSH, RICHARD
Employee/Petitioner

Case# **09WC052062**

10WC039380

AT&T
Employer/Respondent

On 5/14/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

1358 TARADASH LAW OFFICE
908 S ST ROUTE 31
McHENRY, IL 60050

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

15IWCC0074

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

Richard Marsh
Employee/Petitioner

v.

AT&T
Employer/Respondent

Case # **09** WC **52062**

Consolidated cases: **10** WC **39380**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Barbara N. Flores**, Arbitrator of the Commission, in the city of **Chicago**, on **March 11, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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 **Permanent Total Disability pursuant to Section 8(f) of Wage Differential pursuant to Section 8(d)(1)**

15IWCC0074

FINDINGS

On **December 12, 2008**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$18,995.80 (worked 14 weeks)**; the average weekly wage was **$1,258.00**. *See* AX1.

On the date of accident, Petitioner was **53** years of age, ***married*** with **no** dependent children.

Petitioner ***has*** received all reasonable and necessary medical services as explained *infra*.

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

Respondent shall be given a credit of **$10,663.28** for TTD, **$0** for TPD, **$0** for maintenance, and **$60,940.83** for other benefits, for a total credit of **$71,604.11**.

Respondent is entitled to a credit for medical bill payments as reflected in the parties' exhibits totaling **$55,585.65** as agreed by the parties under Section 8(j) of the Act. *See* AX1.

ORDER

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $838.67/week for 11 and 1/7th weeks, commencing June 24, 2009 through September 9, 2009, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from December 12, 2008 through March 11, 2013, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall be given a credit of $10,663.28 for temporary total disability benefits that have been paid.

Maintenance

As explained in the Arbitration Decision Addendum, Petitioner's claim for maintenance benefits is denied.

Medical Benefits

As explained in the Arbitration Decision Addendum, Respondent shall pay the reasonable and necessary medical services incurred by Petitioner at McHenry Orthopedics, excluding a $25 subpoena fee, and Spring Grove Physical Medicine related to treatment of Petitioner's right hand/wrist and submitted in Petitioner's Exhibits 13 and 19 for the dates of treatment identified in the addendum to AX1 to be paid by Respondent as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall be given a credit of $55,585.65 for medical benefits that have been paid as reflected in the parties' exhibits as agreed by the parties, 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. *See* AX1.

15IWCC0074

Permanent Partial Disability

Respondent shall pay Petitioner permanent partial disability benefits of $664.72/week for 30.75 weeks, because the injuries sustained caused the Petitioner 15% loss of use of the right hand, as provided in Section 8(e) of the Act.

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

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

Signature of Arbitrator

May 10, 2013
Date

MAY 14 2013

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION *ADDENDUM*

Richard Marsh
Employee/Petitioner

v.

AT&T
Employer/Respondent

Case # **09** WC **52062**

Consolidated cases: **10** WC **39380**

FINDINGS OF FACT

A consolidated hearing was held in both of Petitioner's above-captioned cases. The issues in dispute in this case are whether Petitioner's condition of ill-being relative to his right hand and wrist are causally related to the December 12, 2008 work accident, whether Petitioner is entitled to the claimed medical, temporary total disability and maintenance benefits, and the nature and extent of Petitioner's injuries, including whether he is entitled to permanent total disability benefits, wage differential benefits or permanent partial disability benefits. Arbitrator's Exhibit ("AX") 1; Arbitration Hearing Transcript ("Tr. at pages") 1-9, 129. The parties have stipulated to all other issues. *Id.*

Background

Petitioner testified that he was employed by Respondent from 1988 through December 12, 2008 as a customer systems technician. Tr. at 15-16, 67-68. Petitioner became a cable splicing technician in September of 2008 because his old position was eliminated and contracted out. Tr. at 19-20. His duties included cutting, placing, and terminating single or multiple pairs of cable wires using tools ranging from a pair of utility scissors to a 40 inch cutter, wrenches, screwdrivers, hammers, single hand or hydraulic crimpers, and a 28 foot fiberglass extension ladder. Tr. at 17-18. Petitioner testified that he carried the ladder from his truck to the work location on his shoulder and estimated that the ladder weighed up to 100 pounds. Tr. at 18-19. He also testified that the cable splicer position additionally required handling and moving heavier cables and working in a manhole which required use of a sledgehammer. Tr. at 20-21. Petitioner is right-hand dominant. Tr. at 40.

Prior Medical Treatment

Petitioner testified that he underwent various surgeries while employed with Respondent. Tr. at 22-23; *see also* PX1, PX8, PX9, PX40-PX43. Petitioner had left knee surgery in 2000 and 2006 with Dr. Niccolai. Tr. at 21-22, 46, 52-53. Petitioner testified that he was eventually released to full duty work after his 2006 left knee surgery. Tr. at 53. He had a lumbar discectomy with Dr. Robbins in July 2000. Tr. at 21. He had a left rotator cuff repair with Dr. Nemickas in January of 2005. Tr. at 21, 46, 51-52. Petitioner testified that he was eventually released to full duty work. Tr. at 52. He had a left carpal tunnel release with Dr. Nemickas in May of 2006. Tr. at 22, 47, 52. Petitioner also had a right carpal tunnel release in July of 2006 with Dr. Nemickas. Tr. at 22, 47. Petitioner testified that he returned to full duty work at some point after this surgery. Tr. at 23, 52. He also testified that his right wrist was good when he returned to full duty work and that he continued to work for Respondent without any injury to the right wrist until December 12, 2008. Tr. at 23-24. Petitioner confirmed this testimony on cross-examination. Tr. at 54.

Thereafter, Petitioner has a cervical fusion on January 28, 2008 with Dr. Citow. Tr. at 22. Petitioner testified that he was eventually released to full duty work. Tr. at 52-53. Then on March 17, 2008, he had a lumbar

fusion with Dr. Citow. Tr. at 22, 47. Petitioner testified that he was eventually released to full duty work. Tr. at 53.

On cross-examination, Petitioner testified that he did not know whether he was released to return to work in May of 2006 after his 2006 left knee surgery. Tr. at 47. He could not answer whether he worked for Respondent between December 12, 2004 and January 19, 2005. Tr. at 45-46. He could not answer whether he was released to return to work on June 16, 2005 after his left shoulder surgery. Tr. at 46. Petitioner did testify that he was placed off work while recovering from both of his carpal tunnel surgeries. Tr. at 47. He further testified that he could not recall the dates during which he received treatment for his low back or when he was released to full duty work. Tr. at 47-48.

After a discussion between the parties' counsel, the parties stipulated that Petitioner was off work related to prior injuries beginning on January 20, 2005 through June 17, 2005, January 11, 2006 through May 26, 2006, and November 1, 2006 through June 26, 2007. Tr. at 49-51. Then on cross-examination, Petitioner testified that from September 15, 2008 through December 12, 2008 he worked full duty without any restrictions. Tr. at 53-54. Additionally, the Arbitrator takes judicial notice of the Commission's own records, which reflect prior cases filed by Petitioner and decisions issued by the Commission in which it made findings of fact and conclusions of law as follows:

(1) *Richard M. Marsh v. SBC*, Case No. 04 WC 58595 after which a review was filed with the Commission and it issued a decision in 08 IWCC 1121 (September 29, 2008). This claim involved an alleged cervical spine injury and addressed medical treatment including other body parts.
(2) *Richard M. Marsh v. SBC*, Case No. 05 WC 55157[1] after which a review was filed with the Commission and it issued a decision in 11 IWCC 328 (April 1, 2011). This claim involved an alleged left knee and low back injury and addressed medical treatment including other body parts.
(3) *Richard M. Marsh v. SBC*, Case No. 05 WC 55158 after which a review was filed with the Commission and it issued a decision in 10 IWCC 337 (April 5, 2010). This claim involved an alleged bilateral carpal tunnel injury and addressed medical treatment including other body parts.

Accident – Right Hand/Wrist

Petitioner testified he was working at the Marshall Field's shopping center under construction in Chicago assigned to place and splice cable in a manhole. Tr. at 24, 54. He was supplying tools and parts from Respondent's truck to the tech in the manhole. Tr. at 24-25. Petitioner testified that he was walking to the rear of the truck to get parts and while reaching up with his right hand to the left door's edge, the wind blew and slammed the right door against the back of his right hand and wrist with great force. Tr. at 25, 54-55. Petitioner described the force with which the truck door slammed on his hand as follows: "It was a really windy day. There were gusts of 50 miles an hour that day. It was great force." Tr. at 25.

Petitioner testified that he immediately noticed pain and swelling, and a large blood bruise on the back of his hand. Tr. at 25-26. Over the following two weeks, Petitioner testified he experienced pain and stiffness although he continued to work full duty. Tr. at 26.

Petitioner testified that he saw his family physician, Dr. Abderholden, on December 29, 2008 at 3:15 p.m.

[1] A second review was filed with the Commission related to late payment of benefits after the initial Commission decision. *Richard M. Marsh v. SBC*, 11 IWCC 328 (June 13, 2012).

although the medical records reflect that Petitioner saw Dr. Devaney at Orchard Medical Center. Tr. at 26, 55; PX1 at 2. The medical records reflect that he reported pain in the top of his right hand after accidentally hitting the back of his hand where an IV had been placed in the recent past. PX1 at 2. Petitioner reported a problem with the vein blowing up when it was hit. *Id.* Petitioner was diagnosed with minor superficial thrombophlebitis on the back of the hand and instructed to return as needed. PX1 at 5. Petitioner testified that he was released to light duty work on December 29, 2008, but no light duty work release is noted in the Orchard Medical Center's records. Tr. at 26-27; PX1.

On cross-examination, Petitioner testified that he scheduled this appointment approximately one week before Christmas. Tr. at 55. He could not recall whether he did anything else on December 29, 2008 including testifying before an Illinois Workers' Compensation Commission Arbitrator in Waukegan with respect to a claim for bilateral carpal tunnel syndrome. Tr. at 55-57. After a discussion between the parties' counsel, the parties stipulated that Petitioner did testify at the Commission on December 29, 2008[2]. Tr. at 58.

Petitioner acknowledged that he testified in a hearing on some date regarding his bilateral carpal tunnel syndrome only and regarding what he noticed about his hands. Tr. at 60. Petitioner recalled testifying that "the carpal tunnel was corrected." Tr. at 60-61. He also recalled testifying that he had "no problems" related to the carpal tunnel. Tr. at 61. On further cross-examination, however, Petitioner also acknowledged testifying at the prior hearing about loss of strength in his hands, a popping or moving sensation in both wrists when he was lifting something heavy, "very, very" little numbness in his hands, and that "I usually do not get pain, unless it is something heavy or really stressful. Otherwise, if it is just, you know, normal light work, I do not have any pain." Tr. at 62-64. During further cross-examination questioning, Petitioner testified that he did not recall whether he testified that he was able to perform his duties as a cable splicer during the December 29, 2008 hearing. Tr. at 64. On redirect examination, Petitioner testified that he was told at the time to only answer questions regarding his carpal tunnel condition and injury. Tr. at 68-69.

On January 28, 2009, Petitioner requested to speak with Dr. Abderholden regarding swelling and pain in his right hand; Petitioner wanted to know if he needed to come in or see a hand specialist. PX1 at 3-4. Petitioner was referred to Dr. Havenhill at McHenry County Orthopedics. Tr. at 27; *see also* PX1 at 6-7, PX2 at 148.

On February 2, 2009, Petitioner returned to the Orchard Medical Center and saw Dr. Soifer with the same complaints as well as numbness and feeling as though a knot or cyst was forming. PX1 at 6-7. Dr. Soifer noted increased swelling and tenderness to palpation on the back of the right hand, referred Petitioner to a hand specialist, and instructed him to return as needed. *Id.*

Petitioner first saw Dr. Havenhill on February 26, 2009. PX2 at 148, 157-159, 163, 189. He reported that his right hand slammed in the door of his truck at work and that it did not really swell at that time, but he had a broken blood vessel which calmed down and formed a small cyst and shortly thereafter he began having swelling in the back of his hand which increased with activity causing a constant, dull, and achy pain at a level of 8-9/10. *Id.* Petitioner also reported worsened pain with bending, lifting, and grasping, as well as at the end of the day. *Id.* On examination, Dr. Havenhill noted diffuse swelling over the dorsum of the hand, thickness about the extensor tendons, but no obvious mass, and a small subcutaneous cyst approximately 3 x 3 mm on the dorsum of the hand that is mobile and not tender. *Id.* He diagnosed Petitioner with possible extensor tenosynovitis in the right hand and ordered an MRI. *Id.* Petitioner was released to full duty work. PX2 at 189.

[2] Case number 05 WC 055158. Tr. at 62-64.

On March 13, 2009, Petitioner returned reporting unchanged symptoms and marked swelling on the dorsum of the hand when using it in any significant way. PX2 at 149. On examination, Dr. Havenhill noted swelling along the extensor tendons distal to the extensor retinaculum, but no significant swelling proximal to the extensor retinaculum. *Id.* Dr. Havenhill reviewed Petitioner's MRI, which he noted showed both flexor and extensor tenosynovitis, most markedly involving the fourth extensor compartment. *Id.* He diagnosed Petitioner with right fourth extensor compartment tenosynovitis and recommended surgery. *Id.*

Petitioner underwent preoperative testing at the Orchard Medical Center on June 24, 2009. PX1 at 8-11. Then, Petitioner underwent his first right wrist surgery on June 25, 2009. PX2 at 206-207; PX3. Pre- and postoperatively, Dr. Havenhill diagnosed Petitioner with right wrist fourth dorsal extensor compartment tenosynovitis, and he performed a right wrist fourth dorsal extensor compartment tenosynovectomy. *Id*; *see also* Tr. at 27.

On June 26, 2009, Dr. Havenhill ordered a wrist splint and physical therapy two times per week for 4 to 6 weeks. PX2 at 188. On July 6, 2009, Petitioner returned to Dr. Havenhill postoperatively and was placed into a wrist splint. PX2 at 150. Petitioner was released to light duty work with use of a wrist splint and no use of the right hand. PX2 at 187. Petitioner underwent physical therapy at Spring Grove from July 13, 2009 through September 4, 2009. PX4.

On August 12, 2009, Petitioner saw Dr. Havenhill and reported that he was not doing as well in therapy as he had hoped; his wrist motion had not improved while his finger motion had improved, and he had no recurrence of tendinosis although he did get swelling on the dorsum of his wrist. PX2 at 151, 156. Petitioner also reported some general discomfort within the wrist. *Id.* On examination, Dr. Havenhill found no evidence of any extensor tenosynovitis. *Id.* He diagnosed Petitioner as status post right forth extensor compartment tenosynovectomy and giant cell tumor excision, and with possible chronic scapholunate ligament tear that may be the underlying cause for his tenosynovectomy that now seems to be symptomatic and causing loss of wrist motion. *Id.* Dr. Havenhill noted that Petitioner's job involved a lot of drills and it seemed reasonable that a chronic tear had developed over years which could be the cause of Petitioner's pain. *Id.* He administered a cortisone injection, recommended continued physical therapy, and scheduled a follow-up appointment in one month. *Id.* Petitioner was released to light duty work with no use of the right hand. PX2 at 185.

On September 9, 2009, Petitioner returned to Dr. Havenhill. PX2 at 152. At trial, Petitioner testified that his right hand was still painful and gave him a lot of problems. Tr. at 27. By contrast, the medical records reflect that Petitioner reported some slight discomfort and numbness and tingling in the small finger, but was otherwise doing well. PX2 at 152. After an examination, Dr. Havenhill noted that he was returning Petitioner back to full duty work and scheduled a follow-up appointment in six weeks. *Id.* He also noted that, given Petitioner's underlying arthritic wrist problem, he was likely to have continuing discomfort and if he experienced significant pain and ability impairment, only major surgery which would forever change his wrist might be a solution if another cortisone injection was ineffective. *Id.* Petitioner was released to full duty work. PX2 at 24; *see also* Tr. at 27.

On October 21, 2009, Petitioner reported a lot of swelling while working with crimping and pliers which was more tolerable and left symptomatic if he was not doing "such heavy repetitive gripping activity" which he localized to the dorsal radial aspect of the right hand. PX2 at 153. After an examination, Dr. Havenhill diagnosed Petitioner with right wrist swelling of unknown origin and indicated that Petitioner had what appeared to be a marked DISI deformity without any significant evidence of osteoarthritis or widening of the scapholunate interval, which Dr. Havenhill questioned might be related to an underlying inflammatory arthritis.

Id. He ordered an inflammatory panel to rule such arthritis out and scheduled Petitioner for follow-up. PX2 at 153, 181. Petitioner was released to full duty work. PX2 at 183.

On November 6, 2009, Petitioner reported having a lot of pain, flare-ups in the wrist when he did any crimping or twisting at work, and barely being able to use his wrist at the end of the day. PX2 at 154. He also reported that he had not yet seen the rheumatologist. *Id.* After an examination, Dr. Havenhill diagnosed Petitioner with right wrist swelling of unknown origin with recurrent extensor tenosynovitis. *Id.* He offered a cortisone injection which Petitioner refused, provided a wrist splint and issued work restrictions including use of a wrist splint, no lifting/pushing/pulling/gripping over 10 pounds with the right wrist, and no repetitive crimping/twisting with the right wrist. PX2 at 154, 179; *see also* Tr. at 27-28.

The medical records reflect that Petitioner called Dr. Havenhill requesting the aforementioned light duty work release. PX2 at 180. Dr. Havenhill again recommended that Petitioner see the rheumatologist before returning to see him. PX2 at 154. Petitioner testified that he began working light duty on Monday, November 9, 2009. Tr. p. 18.

In a letter addressed to "AT&T Disability" dated November 11, 2009, Dr. Havenhill recapped his treatment of Petitioner's right wrist to date, and noted that Petitioner may have an underlying inflammatory arthritis causing his complaints. PX2 at 155, 178. Dr. Havenhill noted his referral of Petitioner to a rheumatologist for further evaluation and that Petitioner's reports had been consistent about work duties exacerbated or aggravating his wrist condition. *Id.*

Petitioner underwent unrelated toe surgery with Dr. Stockey, a podiatrist, in December of 2009. Tr. at 28; *see also* PX1 at 44-45.

On February 15, 2010, Petitioner saw Dr. Vender at Hand Surgery Associates for right wrist pain. PX6 at 274-275; Tr. at 28. Petitioner reported that a truck door slammed onto the dorsal aspect of his hand and wrist, that he was diagnosed with extensor compartment tenosynovitis which was surgically treated, and continued stiffness, limited range of motion, and pain with intermittent swelling in the dorsal aspect of the wrist. PX6 at 274-275. After an examination and review of Petitioner's x-rays, Dr. Vender diagnosed Petitioner with ligament instability in the right wrist and status post right wrist extensor synovectomy. *Id.* Dr. Vender commented that Petitioner's right wrist complaints were consistent with Petitioner's reports of a right wrist injury and subsequent surgery. *Id.* He further noted that a good portion of Petitioner's complaints and examination findings were related to pathology in the wrist, but that it was also possible that the problems came from outside the wrist given Petitioner's history of extensor tenosynovitis and subsequent surgery. *Id.* Dr. Vender recommended wrist arthroscopy, noted that Petitioner was still under the care of his prior treating physician, and instructed Petitioner to return as needed. *Id.* Dr. Vender did not impose work restrictions because he did not know if Petitioner would continue to treat with him or return to his prior treating physician. PX23 at 706.

On March 1, 2010, Dr. Vender noted that Petitioner's main problem appeared to be ligament instability in the right wrist and he recommended surgery including possible scaphoid excision with a partial wrist fusion utilizing a bone graft vs. a proximal row carpectomy involving removal of the scaphoid, lunate and trapezium bones as the most definitive treatment for Petitioner's condition. PX6 at 276. Dr. Vender placed Petitioner on light duty work with use of the splint and no lifting/pushing/pulling over 10 pounds. *Id.*; Tr. at 28-29.

On April 6, 2010, Petitioner testified that his supervisor, Mr. Banker, informed him that there was no more light

duty work available. Tr. at 29. This was the last day that Petitioner physically worked for Respondent. Tr. at 29.

Section 12 Examiner – Dr. Carroll

Dr. Carroll submitted to a deposition on January 26, 2011 during which he was questioned about his independent medical evaluation of Petitioner's right wrist and hand at Respondent's request, his opinions regarding Petitioner's condition of ill being and its relation, if any, to Petitioner's accident at work on December 12, 2008. RX1. Dr. Carroll authored a report after his examination of Petitioner on May 3, 2010. RX1 (Dep. Exh. 2).

At the time of Petitioner's evaluation on May 3, 2010, Petitioner reported difficulty with his right hand and wrist as of December 12, 2008 when "he was closing a door of a work truck[…, which he closed] on the dorsum and center portion of the right hand. He had swelling and apparently a broken blood vessel." RX1 (Dep. Exh. 2). After an examination and review of various treating medical records, Dr. Carroll opined that Petitioner had received appropriate care for a contusion of the dorsum of the right hand, that the tenolysis was appropriate but unrelated to his injury at work, that Petitioner reached maximum medical improvement approximately six months after his surgery of the right hand, and that Petitioner needed no restrictions as a result. *Id.*, RX1 at 12-14. At his deposition, Dr. Carroll clarified that "the need for care for the tenolysis, the contusion and the tenosynovectomy performed by Dr. Havenhill was caused by the injury in question, required treatment and did improve." RX1 at 13 (emphasis added).

Dr. Carroll also opined that Petitioner had evidence of scapholunate instability and that the treatment by Dr. Vender was appropriate and might require reconstructive surgery later on, however, this condition was not related to Petitioner's injury at work and that he would require further information about the weight of the door, pictures, and perhaps other documentation to determine whether there was any relationship between the wrist instability and the injury at work. *Id.*; RX1 at 12-15. At his deposition, Dr. Carroll expounded on his opinion and testified that generally one would expect to see scapholunate instability as a result of a compressive force/significant trauma which would drive the wrist bones apart and rip the ligaments, which was not present in Petitioner's case. RX1 at 14-16.

On cross examination, Dr. Carroll further testified that the type of force necessary to cause wrist instability in the manner described by Petitioner would require a "very, very, very heavy door, I am not sure, something like an 18-wheeler truck door type of thing was swung in a 40, 50-mile an hour wind and the wrist got caught in the door came across the wrist and crushed the wrist pretty hard and caught the wrist in the door, that might cause it. But it wouldn't be a door just struck a glancing blow and caused it. So it would be a very significant force with a very heavy door, hence the questions that I asked that might or could cause that. I've not heard data to suggest that's the case to date." RX1 at 22-23. He acknowledged that the velocity at which the door swung would affect the amount of force necessary to cause Petitioner's wrist instability. RX1 at 23-24. Dr. Carroll also testified that he was not aware that Dr. Vender performed surgery on Petitioner on August 31, 2010. RX1 at 26-27.

Continued Medical Treatment

On July 12, 2010, Petitioner returned to Dr. Vender for examination of the bilateral upper extremities with the right side being more symptomatic, pain radiating proximally, and developing symptoms on the left side. PX6 at 277. He kept Petitioner on light duty work with use of the splint and no lifting/pushing/pulling over 10

pounds and instructed him to return as needed. *Id.*

In a letter dated July 22, 2010 addressed to Petitioner's counsel, Dr. Vender noted his review of certain of Petitioner's medical and physical therapy records and Dr. Carroll's independent medical evaluation dated May 3, 2010. PX6 at 295-297. Dr. Vender indicated as part of his opinion on causation that there "are no indications of a pre-existing wrist condition[,]" but he ultimately opined that it was not unreasonable to assume that Petitioner could have undergone an injury to the tendons adjacent to the ligaments in question resulting in the injury that necessitated the surgical intervention performed by Dr. Havenhill in the surgical intervention recommended by Dr. Vender. *Id.*

Petitioner underwent his second right wrist surgery with Dr. Vender on August 31, 2010. PX6(a) at 319-320; Tr. at 29. Preoperatively, Dr. Vender diagnosed Petitioner with right wrist pain and carpal instability. *Id.* Dr. Vender performed right wrist arthroscopic debridement. *Id.* Postoperatively, he diagnosed Petitioner with right wrist pain and carpal instability plus scaphoid chondromalacia, triangular fibrocartilage complex (TFCC) tear, and ulnar impaction. *Id.*

Petitioner testified that at his first physical therapy evaluation on September 3, 2010, the "physical therapist noticed that I was not moving my right shoulder properly." Tr. at 29-30. Petitioner also testified that he experienced pain and that he could not reach above his head using his right shoulder. Tr. at 29-30. The Arbitrator notes that Petitioner did not explain how he knew what the physical therapist noticed about him. A physical therapy note of the same date reflects "Pt placing (R) shoulder in awkward positions to perform functional tasks." PX7 at 325.

Petitioner returned postoperatively on September 9, 2010, at which time Dr. Vender discussed Petitioner's surgical findings, recommended a proximal row carpectomy, and ordered occupational therapy. PX6 at 278; *see also* Tr. at 29. He also noted that given Petitioner's "underlying wrist arthritic problem, he is likely to have some continuing discomfort." *Id.* Petitioner returned on September 16, 2010 and was restricted to sedentary work only. *Id.*

On September 28, 2010, Petitioner underwent his third right wrist surgery with Dr. Vender. PX6(b) at 321-322; Tr. at 31. Pre-and postoperatively, Dr. Vender diagnosed Petitioner with right wrist derangement with carpal instability, arthritis, and extensor lower tenosynovitis. *Id.* He performed a right wrist proximal row carpectomy and right wrist extensors tenolysis and tenosynovectomy of the second, third, fourth, and fifth compartment. *Id.*

Petitioner returned postoperatively on September 30, 2010, at which point Dr. Vender placed Petitioner in a short arm cast, discussed surgical intervention for symptomatology on the left side, and placed Petitioner off work. PX6 at 280. Petitioner continued to follow up with Dr. Vender postoperatively through December 27, 2010. PX6 at 281-284. During that time, Dr. Vender restricted Petitioner to light duty work only until his full duty release on December 27, 2010. *Id.*; *see also* Tr. at 32. Petitioner also underwent physical therapy as ordered by Dr. Vender. PX6 at 291-292.

Thereafter, Petitioner underwent left wrist surgery on January 4, 2011 for an unrelated medical condition. PX6(c) at 323-324; Tr. at 32-33.

Dr. Vender

Dr. Vender submitted to a deposition on November 22, 2010 during which he was questioned about his

treatment of Petitioner's right wrist and his opinions regarding Petitioner's condition of ill being and its relation, if any, to Petitioner's accident at work on December 12, 2008. PX23. Dr. Vender opined that his diagnoses of Petitioner were consistent with Petitioner's reported mechanism of injury because the localization of Petitioner's wrist abnormality was in the area of trauma identified by himself and Dr. Havenhill, and because Petitioner's TFCC tear and ligament injury was consistent with trauma as opposed to a degenerative condition. *Id.*, at 707-709, 720-721.

Dr. Vender testified that he was unable, however, to comment on Dr. Havenhill's chronic scapholunate ligament tear diagnosis. *Id.*, at 712-714. Dr. Vender could not tell the age of Petitioner's x-ray findings from Petitioner's first visit to him in February such that he could render an opinion whether Petitioner's ligament tear resulted from a chronic condition or acute injury. *Id.* He added that for Dr. Havenhill to describe that Petitioner's scapholunate ligament tear as chronic "... he'd have to have some kind of visible arthritis [in Petitioner's x-ray findings] to say that it was chronic. Otherwise, again he is not in a position necessarily to say that those x-ray findings acute [sic] or chronic." *Id.* Dr. Vender was not aware of Petitioner having any symptoms attributable to scapholunate instability prior to his injury at work. *Id.*, at 722.

Dr. Vender also testified that when he first saw Petitioner, he did not describe how he was standing at the time of the accident, the position of his hand in the door, whether the door was a sliding or swinging door, and that he did not recall whether he had any treating medical record of Petitioner's treatment from December of 2008 until Petitioner began treating with Dr. Havenhill. *Id.*, at 724-725. Dr. Vender further testified that force is a factor affecting whether the type of injury sustained by a patient in a traumatic accident, but that force was difficult to quantify. *Id.*, at 722-723.

The Arbitrator notes that Dr. Vender was not questioned about and he did not testify regarding Petitioner's permanent disability, if any, or permanent restrictions.

Right Shoulder Treatment

Dr. Abderholden referred Petitioner to Dr. Nemickas for a right shoulder evaluation. PX8 at 333-334. Petitioner saw Dr. Nemickas for the first time on January 17, 2011. *Id.* Petitioner reported "right shoulder pain and discomfort times many year's duration." *Id.* He also reported that the right shoulder pain and discomfort had progressed while on the job and that he carried a two-section ladder on his right shoulder, which he was usually able to manage with activity modification. *Id.* Petitioner further reported undergoing treatment for bilateral wrist injuries and that in the process of recovery he favored his right shoulder with worsening pain and discomfort which impeded his activities of daily living, caused difficulty sleeping, and trouble getting through the course of the day. *Id.* On examination, Petitioner had hypertrophy at the AC joint, positive impingement, and decreased rotator cuff strength in the scapular plane at 3+/5. *Id.* Additionally, Petitioner was not tender to palpation, had negative crossover/provocative biceps/SLAP/labral tests, focal he intact CMS without deficits, and no tenderness in the arm/forearm/hand compartments. *Id.*

Petitioner underwent right shoulder x-rays which Dr. Nemickas noted showed evidence of AC joint hypertrophic, type II acromion, and no acute fracture/dislocation. *Id.* He diagnosed Petitioner with right shoulder presumed occult internal derangement, ordered a right shoulder MRI, and did not impose any additional medical restrictions given that Petitioner's left wrist work restrictions exceeded what he would have imposed. *Id.*

On January 26, 2011, Petitioner returned to Dr. Nemickas reporting continued and unchanged right shoulder

pain and discomfort. PX8 at 336-337. Dr. Nemickas reviewed Petitioner's January 21, 2011 MRI and diagnosed him with a right shoulder rotator cuff tear with concomitant SLAP tear and bicipital rupture. *Id.*; PX8(a) at 509-509. The interpreting radiologist noted that Petitioner's right shoulder MRI showed the following: (1) a small to moderate joint effusion with significant degenerative changes acromioclavicular joint; and (2) full-thickness tear supraspinatus tendon and bicipital tendon with some retraction of each structure and a sprain of the intact subscapularis tendon. PX8(a) at 508-509. Dr. Nemickas noted that Petitioner understood that "his years of service in carrying the 100-pound sectional ladder have resulted in an internal derangement of his shoulder in which he has ruptured both his bicipital tendon as well as his rotator cuff." PX8 at 336-337. Dr. Nemickas recommended surgery. *Id.*

On January 28, 2011, Petitioner underwent preoperative testing at Orchard Medical Center. PX1 at 46-51, 53-55.

On January 31, 2011, Dr. Vender released Petitioner from care for both hands. Tr. at 33. Petitioner testified that he was placed on permanent work restrictions. Tr. at 33-34.

On February 9, 2011, Petitioner underwent right shoulder surgery with Dr. Nemickas. PX9 at 511-512; Tr. at 34. Preoperatively, Dr. Nemickas diagnosed Petitioner with right shoulder internal derangement. *Id.* He performed the following procedures: (1) examination under anesthesia, diagnostic arthroscopy, and debridement; (2) biceps tenodesis; (3) rotator cuff repair; (4) arthroscopic subacromial decompression; and (5) arthroscopic Mumford. *Id.* Postoperatively, Dr. Nemickas diagnosed Petitioner with chronic bicipital tenosynovitis, extensive synovitis, rotator cuff tear, subacromial impingement, and advanced acromioclavicular joint degenerative joint disease. *Id.* Petitioner testified that he was placed off work. Tr. at 34-35; *see also* PX9.

Petitioner testified that he separated from Respondent's employment on February 11, 2011. Tr. at 35, 66. On cross-examination, Petitioner testified that he remained under active medical care for that his right shoulder and left hand at this time. Tr. at 66.

The medical records reflect Petitioner saw Dr. Nemickas postoperatively on February 21, 2011. PX8 at 339. Dr. Nemickas ordered physical therapy once a week for four weeks, use of his arm sling, and to return for follow up in one month. *Id.* Petitioner returned on March 21, 2011 at which time Dr. Nemickas noted that Petitioner had given consideration to returning to work and that he did "not believe that [Petitioner] will recover to the point that he will be able to do a U.S. Department medium-heavy to heavy labor particularly overhead work and carrying above aforementioned loads [i.e., 100-pound two-piece ladder] across the shoulder girdle at this time...." *Id.* Dr. Nemickas kept Petitioner off work.

Petitioner was referred for a functional capacity evaluation, which he underwent on March 16, 2012. Tr. at 35; PX10 at 620-636. The test results and Petitioner's efforts were deemed to be valid. *Id.*

The physical therapist noted that the FCE referral was for Petitioner's right shoulder arthroscopy in February of 2011 however Petitioner stated "that is not his limiting factor. He feels he is undergoing this test due to right wrist and hand pain, but is limited with several parts of his body." PX10 at 622. Petitioner reported undergoing 15 surgeries over the prior 10 years for body parts not affected by either accident at issue in either of Petitioner's claims (i.e., left knee, toe, left shoulder, neck, left hand, etc.). *Id.* Petitioner reiterated that "[h]e want it noted his right shoulder arthroscopy was the last surgery performed but he feels that bilateral wrists, back, and left knee limit his activities." PX10 at 634. Petitioner reported that he did not think that he was capable of doing any jobs. PX10 at 635.

Ultimately, the physical therapist determined that Petitioner had "multiple restrictions and limiting factors that will make it difficult to find a suitable job in the future. He is in the sedentary category but is unable to sit or stand for prolonged periods, as well as he is unable to perform fine manipulation or grip." PX10 at 620-621, 635-636.

On May 2, 2011, Petitioner followed up with Dr. Nemickas who ordered additional physical therapy, kept him off work, and scheduled a follow up in approximately 6 to 8 weeks. PX8 at 342.

Approximately 8 months later on January 4, 2012, Petitioner returned to Dr. Nemickas reporting the ability to perform routine activities of daily living without appreciable difficulty, some intermittent soreness and discomfort anterolaterally with mild sleep disturbances at times which were fairly limited with modification and associative use of modalities. PX8 at 343. Dr. Nemickas commented that Petitioner was "not going to be able to return to work as a lineman for Ameritech as he will no longer be able to safely ascend and descend ladders or scaffolds and poles nor be able to tolerate carrying the bi-fold ladder along the top of his shoulder girdle due to the underlying concomitant structural changes. Particularly, the degenerative change to the region and the associative tearing and repaired tissues." *Id.* He recommended vocational retraining and rehabilitation without exertion across the shoulder or exposure to eccentric loads associated with pulling the wire. *Id.* Petitioner was instructed to return as needed and discharged from treatment. *Id.*

Section 12 Report – Dr. Bach

Petitioner submitted to an independent medical evaluation with Dr. Bach at Respondent's request on June 18, 2012. PX36. Dr. Bach noted that Petitioner refused to answer any of his questions and he thought of the independent medical evaluation and delays related to the independent medical evaluation as "a game." *Id.* Moreover, Dr. Bach noted that Petitioner refused to answer any questions related to Petitioner's job duties or even his job title. *Id.* After his review of a summary of Petitioner's medical treatment provided by Respondent's counsel, various medical records, interviewing Petitioner to little avail, and a physical examination, he opined that Petitioner's work duties caused his right shoulder condition. *Id.*

Dr. Nemickas

Dr. Nemickas submitted to a deposition on March 23, 2013 during which he was questioned about his treatment of Petitioner's right shoulder, his opinions regarding Petitioner's condition of ill being and its relation, if any, to Petitioner's work activities, and Petitioner's ability to work. PX35. In response to a lengthy hypothetical question and follow up questioning, Dr. Nemickas ultimately opined that Petitioner's right shoulder internal derangement condition was causally related to his repetitive activities while working for Respondent over 22 years including lifting, carrying, walking with, and balancing a 100-pound ladder while placed over the right shoulder. PX35 at 778-783.

On cross examination, Dr. Nemickas acknowledged that on the date of Petitioner's initial visit he was not aware how long Petitioner had worked for Respondent, whether Petitioner was still working for Respondent, the weight of Petitioner's ladder, or how often he carried the ladder. *Id.*, at 784-790. Dr. Nemickas also testified that Petitioner felt that his right shoulder condition had developed from chronic use at work. *Id.*, at 790.

Dr. Nemickas also testified that that Petitioner reported a date of onset for his right shoulder condition of September 3, 2010 without explanation. *Id.*, at 785-786. The Arbitrator notes that this is the date on which

Petitioner testified that a physical therapist noticed that he was not properly using his right shoulder.

Dr. Nemickas also testified that regarding his postoperative diagnoses. PX35. He acknowledged that Petitioner's chronic bicipital tenosynovitis as diagnosed by him postoperatively could have resulted from degeneration or an acute injury or some type of repetitive use involving force, whether at work or elsewhere. *Id.*, at 790-791. He testified that extensive synovitis could be part of a degenerative condition. *Id.*, at 791-792.

Dr. Nemickas also acknowledged that the usual and customary return to work after surgery would have been 6 to 8 weeks after Petitioner's May of 2011 surgery. *Id.*, at 795-796. Dr. Nemickas did not see Petitioner again until January 4, 2012, so he was unable to opine on Petitioner's functional capability regarding the right shoulder at that time. *Id.* He further testified that he did not know whether Petitioner was working through January of 2012 and he declined to opine on whether Petitioner could return to work as a splicer because he had not seen Petitioner's splicer job description. *Id.*, at 797-799.

Medical Bills

Petitioner submitted a variety of bills for medical treatment for which he claims Respondent is liable related to reasonable and necessary treatment for his right hand/wrist and right shoulder. Petitioner testified that, other than Dr. Havenhill's first bill, his medical bills from December 29, 2008 through September 3, 2010 relating to his right hand were not paid by the workers' compensation insurance; some bills were paid by his group health insurance and some were paid by him out of pocket. Tr. at 41-42.

Sedgwick CMS authorized various services including a right hand MRI, Petitioner's surgery with Dr. Havenhill, occupational therapy for 8 visits, and a wrist splint. PX2 at 174-175, 177, 197.

Additional Information

Petitioner testified that he is a "hunting and poke" computer user. Tr. at 40. He testified that he is a "sport man" and generally uses the computer for e-mails and online purchases. *Id.* Petitioner is not currently employed. Tr. at 41.

Regarding his right hand and wrist, Petitioner testified that he has pain, swelling, and cramping in the fingers with any repetition in the right hand and wrist. Tr. at 35-36. Petitioner described difficulty with repetition stemming from household activity including dishes, wiping off counters, sweeping, vacuuming, tightening buttons, tying/untying shoelaces, knotting, bathing, and brushing his teeth. Tr. at 36-37. He also testified that he has a hard time with his fingers if he writes or prints for too long, he has a big problem with paging through newspapers, magazines, or books, he has difficulty picking up and grasping small objects like pens or papers, and if he adds any weight whatsoever to his right hand with tools, a hammer, a screwdriver, or a wrench, to use those tools "it makes it worse." Tr. at 37-40.

On cross-examination, Petitioner testified that he is an outdoor sportsman who liked to fish and hunt, but that he had not fished since his accident and that he only engages in limited bird and small game hunting using a 12gauge shotgun. Tr. at 66-67. To use the shotgun, Petitioner uses his right shoulder and also uses his right index finger to pull the trigger. Tr. at 67. The Arbitrator notes that Petitioner did not testify about any current condition of ill-being or symptomatology related to his right shoulder.

Vocational Rehabilitation – Mr. Belmonte

Joseph Belmonte ("Mr. Belmonte") testified that he is employed by Vocamotive and that he is a certified rehabilitation counselor. Tr. at 71-74. At Petitioner's counsel's request, Mr. Belmonte prepared a vocational evaluation report dated January 30, 2012. Tr. at 74; PX37. Mr. Belmonte testified that he did not have a lot of detailed information about Petitioner's residual physical capacity to have a real understanding of what Petitioner could or could not do. Tr. at 81-82, 114. Mr. Belmonte's report reflects that "it should not be assumed that [Petitioner] is employable at any level.... [and that] a comprehensive vocational evaluation is necessary before any determination along those lines can be made or assumed." PX37 at 828-829.

At Petitioner's counsel's request, Mr. Belmonte authored a supplemental evaluation report dated April 10, 2012. Tr. at 82, 116; PX38. Mr. Belmonte reviewed Petitioner's functional capacity evaluation and found it remarkable that Petitioner did not complete certain portions of the test including dynamical lifting or carrying because the evaluator considered Petitioner's lifting and carrying mechanics to be unsafe. Tr. at 84-86. Mr. Belmonte also noted that the FCE evaluator modified lifting protocol for Petitioner's test and that Petitioner's performance was slow or limited with regard to certain testing activities. Tr. at 86-87.

Ultimately, Mr. Belmonte determined that Petitioner had lost access to his usual and customary job/line of occupation as well as the jobs/occupations that he historically performed, did not currently have any viable, stable labor market offering gainful employment available to him, and that Petitioner's physical restrictions did not facilitate a match with any reasonably well-known occupation including any unskilled or low skilled positions such that vocational rehabilitation was not viable. PX38.

At trial, Mr. Belmonte testified that there was nothing outside of his original or supplemental reports that he considered in reaching his conclusions that he failed to note in either report. Tr. at 91. On cross-examination, however, Mr. Belmonte testified that he performed a transferable skills analysis based on his knowledge, experience, and the information provided to him about Petitioner, but that he did not detail how he reached his conclusion about the transferability of Petitioner's skills in his report. Tr. at 119-123.

Mr. Belmonte reviewed the vocational assessment report and labor market survey authored at Respondent's request. Tr. at 98-99; *see also* RX2-RX3. He noted that Ms. Allen referenced an independent medical evaluation report authored by a Dr. Bach which he had not seen. Tr. at 101.

Mr. Belmonte disagreed with Ms. Allen's opinion that any of the jobs identified by Ms. Allen work available to Petitioner because Petitioner's FCE results were based on a "heavily modified" evaluation "in order to gain any measurement of [Petitioner's] lifting capacity...[]" and Petitioner's limitations identified in the FCE. Tr. at 102-104. Mr. Belmonte testified that in virtually any occupation that he could think of, Petitioner would require some kind of accommodation based on Petitioner's FCE results and that "[t]he reality is there are very few, if any, jobs in the US economy that do not require use of the hands." Tr. at 104-106.

On cross-examination, Mr. Belmonte testified that an FCE is a diagnostic tool and, essentially, must be viewed in conjunction with any examining physician his review of the FCE results. Tr. at 116-17. Ultimately, one must refer to the expert medical opinion of the physician, unless he or she concurs with the FCE results, and that it is the physician's ultimate responsibility to release a patient to return to work or not. Tr. at 117-118.

Vocational Rehabilitation – Ms. Allen

Samantha Allen ("Ms. Allen") testified that she is employed by Encore Unlimited and that she is a certified rehabilitation counselor. Tr. at 130; *see also* RX2. At Respondent's counsel's request, Ms. Allen prepared a vocational evaluation report dated November 29, 2012. Tr. at 133; RX2. Ms. Allen testified that a labor market survey was prepared at Respondent's request on September 11, 2012 by her co-worker, Alla Massat ("Ms. Massat"), which is kept in the ordinary course of her business and upon which she relied in reaching her conclusions regarding Petitioner's employability. Tr. at 133-135; RX3.

Ms. Allen testified that she utilized a program from VocRehab.com to perform a transferable skills analysis and that her report does not contain the complete list of occupations or parameters that she used and that are available for input as criteria into the VocRehab.com program because, essentially, she had to use common sense, her experience, and jobs available in the labor market to find the best match for Petitioner and retain only jobs that she felt were appropriate for Petitioner. Tr. at 137-140, 154-166, 176-177. Ms. Allen also testified that the jobs listed in the labor market survey actually existed in the job market. Tr. at 140-141.

Ms. Allen reviewed a vocational evaluation report authored by Lisa Byrne ("Ms. Byrne") dated January 30, 2013. Tr. at 141-142; PX47. Ms. Byrne ultimately determined that very few employment possibilities existed for Petitioner given his work history, testing results, achievement levels, reasoning, aptitudes, physical abilities and limitations, and results of a transferrable skills analysis. PX47.

Ms. Allen testified that she used to work with Ms. Byrne at Coventry. Tr. at 142. Ms. Allen disagreed with some of the opinions contained in Ms. Byrne's report including that there were minimal occupations in which Petitioner could engage, Petitioner could not work eight hours per day, and Petitioner had very few employment possibilities which required a highly accommodated environment. Tr. at 142-144. Ms. Allen also testified that Petitioner's Wide Range Achievement Test ("WRAT-4") results support Ms. Allen's conclusion that Petitioner is a vocational rehabilitation candidate because he has the ability to learn a new occupation and undergo on-the-job training based on his test results. Tr. at 144-145. Ms. Allen further noted that the COPS survey identified in Ms. Byrne's report is a self-directed inventory test taken by the injured worker. Tr. at 150-151.

Additionally, Ms. Allen reviewed Mr. Belmonte's reports. Tr. at 146. She disagreed with Mr. Belmonte's conclusion that Petitioner is not employable, that Petitioner is not a candidate for even the most unskilled or low skill employment (e.g., security worker, cashier, retail salesperson, etc.), and she testified that she did in fact find employment matches for Petitioner. Tr. at 146-148. Ms. Allen added that certain positions would require a reasonable accommodation for Petitioner's physical capabilities. Tr. at 148-149. On redirect examination, she testified that it was not her intention when she listed those jobs to mean that Petitioner could work in these positions without any accommodation or consideration for his specific needs. 179-180.

On cross-examination, Ms. Allen was questioned about various jobs identified in Petitioner's group exhibit 49. Tr. at 166-175. She acknowledged that there were physical requirements and these job descriptions that were outside of Petitioner's physical capabilities, but testified, essentially, that Petitioner would need reasonable accommodations to perform these jobs. *Id.* She also acknowledged that she did not know the difference between material handling, handling, and fingering noted in the Dictionary of Occupational Titles assignment clerk job description contained in the physical demands portion of the description. PX49(a) at 4. On redirect examination, Ms. Allen testified that there might be a job category in the labor market that is not specifically called assignment clerk and that does not actually require frequent reaching, handling, or fingering. Tr. at 178.

ISSUES AND CONCLUSIONS

The Arbitrator hereby incorporates by reference the Findings of Fact delineated above and the Arbitrator's and parties' exhibits (AX1, PX1-PX25, PX34-PX44, PX47-PX49, RX1-RX3) are made a part of the Commission's file. After reviewing the evidence and due deliberation, the Arbitrator finds on the issues presented at trial as follows:

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

The Arbitrator finds that Petitioner's claimed current right hand/wrist condition of ill-being is not causally connected to the undisputed work accident on December 12, 2008. In so finding, the Arbitrator first addresses Petitioner's credibility.

While the parties stipulated that Petitioner sustained an injury at work on December 12, 2008, they dispute whether Petitioner's claimed current condition of ill-being in the right hand/wrist is causally related to that injury and, if so, to what extent. At trial, the parties submitted the deposition testimony of one of Petitioner's treating physicians, Dr. Vender, and Respondent's Section 12 examiner, Dr. Carroll. Both doctors relied on the accident description reported to him by Petitioner and as reflected in the medical records available to each for review. Thus, Petitioner's recitation of the mechanism of injury at trial and in his reports to various physicians is significant not only with regard to credibility, but also with regard to the causal connection opinions rendered by Dr. Vender and Dr. Carroll. The Arbitrator finds that the accident as described by Petitioner at trial is inconsistent with his reports to various physicians. The medical records reflect a different version of the mechanism of injury as reported by Petitioner; one that increased in severity with the passage of time.

At trial, Petitioner testified that he was walking to the rear of the truck to get parts and while reaching up with his right hand to the left door's edge, the wind blew on a day of 50 mile per hour gusts of wind and "slammed" the right door against the back of his right hand and wrist with "great force." The clarity and specificity with which Petitioner testified about the severity of the accident and the mechanism of injury at trial is lacking in Orchard Medical Center's initial treatment records of December 29, 2008. These records reflect, by contrast, that when Petitioner first sought medical attention for his right hand/wrist 17 days after his injury at work on December 29, 2008—during which time he sought no medical attention—he reported pain in the top of his right hand after "accidentally hitting" the back of his hand where an IV[3] had been placed in the recent past. Petitioner explained the problem to be with the vein then "blowing up" when he hit it.

On December 29, 2008, Petitioner did not report any injury at work occurring in any fashion. There is no mention of any involvement of a truck door. There is no reference to any 50 mile an hour gusts of wind causing a truck door to slam into his right hand. Interestingly, the only time that Petitioner reported 50 mile an hour winds on the date of accident was at trial. He did not do so during any of his medical treatment and he did not report this to Dr. Carroll during his examination. The only other reference to specific "mile per hour" winds was made by Dr. Carroll during his deposition when he was articulating various elements that could result in the amount of force required to cause Petitioner's claimed wrist condition from a traumatic event. Dr. Carroll referred to 40 to 50 mile an hour winds. The Arbitrator notes the coincidence of Petitioner's assured

[3] Notably, Petitioner did not testify at trial regarding any IV being placed in his right hand before "accidentally hitting" it, why he had an IV in his right hand, and no medical records were submitted into evidence related to any medical treatment requiring the placement of an IV.

recollection at trial during direct examination of the speed of the winds occurring on the date of accident and the lack of any such detailed report to any of his treating physicians or even Dr. Carroll.

Moreover, there is no indication that Petitioner's right hand injury occurred as a result of any great force. In fact, Dr. Devaney diagnosed Petitioner with only a minor superficial thrombophlebitis on the back of the hand and instructed him to return as needed. The first time that Petitioner's treating medical records contain any reference to work or an accident involving any type of force or severity (i.e., "accidentally hitting" his right hand v. his right hand being "slammed" in a work truck door) occurred 2 ½ months after his accident date when he saw Dr. Havenhill on February 26, 2009 and described that his right hand was "slammed" in the door of his work truck.

Petitioner's credibility is further eroded by the inconsistencies between his testimony during direct examination compared to his testimony during cross examination. While Petitioner had no problem recalling events or articulating matters with specificity and at length during questioning by his attorney, his memory repeatedly failed him on cross examination. Moreover, Petitioner was obstinate during cross examination and he refused to testify to certain matters from memory without consulting notes that were not available to him at trial, whereas he freely did so on direct and re-direct examinations.

Remarkably, Petitioner testified on cross examination that he could not recall whether he testified before an Arbitrator at the Illinois Workers' Compensation Commission in Waukegan with respect to an alleged bilateral carpal tunnel syndrome claim on the same date that he first received treatment for this new injury to the right hand. Petitioner has previously filed three claims against this Respondent for injuries to various body parts. The Arbitrator is not persuaded that Petitioner's memory could fail so miserably on cross examination that he could not recall if he testified at a trial involving his alleged bilateral carpal tunnel syndrome on the same day that he first sought medical treatment for what he would now have the Arbitrator believe is a severe right hand/wrist injury resulting from 50 mile an hour gusts of wind slamming a truck door on his right hand with great force causing him, at worst, to be permanently and totally disabled. Based on all of the foregoing, the Arbitrator finds that Petitioner's testimony at trial is not credible.

Second, the Arbitrator addresses the causal connection opinions of Dr. Vender and Dr. Carroll. Dr. Vender opined Petitioner's ligament injury and instability and previously treated extensor synovitis were consistent with Petitioner's reported mechanism of injury that a truck door "slammed" onto the dorsal aspect of his right hand because the localization of Petitioner's wrist abnormality was in the reported area of trauma. At his deposition, however, Dr. Vender conceded that he was missing certain information regarding Petitioner's medical history from December of 2008 until Petitioner's treatment with Dr. Havenhill. Dr. Vender also declined to opine on whether Petitioner's scapholunate ligament tear was the result of a chronic condition or an acute injury and he explained that Dr. Havenhill must have had some visible x-ray evidence of arthritis to describe Petitioner's scapholunate tear as chronic in his records. He further acknowledged that at Petitioner's first visit, Petitioner did not describe how he was standing at the time of the accident, the position of his hand in the door, or the type of door that injured Petitioner, and he conceded that force is a factor affecting the type of injury sustained by a patient in a traumatic accident such as that claimed by Petitioner.

Respondent's Section 12 examiner, Dr. Carroll, ultimately opined that Petitioner sustained a contusion of the right hand requiring the medical treatment rendered by Dr. Havenhill and that Petitioner reached maximum medical improvement approximately 6 months after his surgery of the right hand after which he could work full duty. Dr. Carroll opined that Petitioner's scapholunate instability was not related to Petitioner's injury at work given Petitioner's reported mechanism of injury and the lack of objective medical evidence showing a

compressive force/significant trauma which would drive the wrist bones apart and rip the ligaments, which one would normally see in the type of injury claimed by Petitioner which was not present in Petitioner's case.

Moreover, no testimony was proffered from Dr. Havenhill. While the Arbitrator notes that he indicated in his records on August 12, 2009 that Petitioner's chronic scapholunate tear may have been caused or aggravated by Petitioner's job involving the use of a lot of drills, Petitioner does not assert that his right hand/wrist condition was caused by any repetitive trauma or overuse at work. Thus, the Arbitrator considers that Petitioner waives any such argument.

Given the inconsistencies in Petitioner's reported mechanism of injury to various physicians, the reliance of Dr. Vender and Dr. Carroll on Petitioner's accident descriptions to reach their opinions on causal connection at least in part, and Dr. Vender's lack of medical records of Petitioner's medical treatment from December 2008 through February 25, 2009 before he saw Dr. Havenhill, the Arbitrator finds the opinions of Dr. Carroll to be more persuasive than those of Dr. Vender in this case.

Third, the Arbitrator addresses the extent of causal connection between Petitioner's work accident and his claimed current condition of ill-being. As explained herein, the Arbitrator finds that Petitioner's testimony is not credible and repeatedly inconsistent with medical record evidence, and also finds that the opinions of Dr. Carroll are persuasive. The Arbitrator notes, however, that Dr. Havenhill released Petitioner to full duty work approximately three months after his surgery on September 9, 2009. It was Petitioner that returned to Dr. Havenhill twice thereafter in October and November of 2009 requesting light duty restrictions, which Dr. Havenhill imposed despite the fact that Petitioner refused a cortisone injection as recommended by Dr. Havenhill to address any continued symptomatology and Petitioner's failure to see a rheumatologist after three written notations or recommendations by Dr. Havenhill that Petitioner should do so to address his symptoms. Notwithstanding, the Arbitrator defers to the medical opinions rendered by Dr. Carroll and finds that Petitioner reached maximum medical improvement an estimated 6 months after his surgery with Dr. Havenhill and that causal connection between his injury at work and his claimed current condition of ill-being ceased at that time.

Based on all of the foregoing and in light of the totality of the record, the Arbitrator finds that Petitioner's claimed current right hand/wrist condition of ill-being is not causally connected to his December 12, 2008 accident at work.

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:

As explained in detail above, the Arbitrator finds that Petitioner has established causal connection to the extent opined by Section 12 examiner, Dr. Carroll. At his deposition, Dr. Carroll clarified that Petitioner's need for "care for the tenolysis, the contusion and the tenosynovectomy performed by Dr. Havenhill was caused by the injury in question, required treatment and did improve." With regard to outstanding medical bills for treatment rendered by Dr. Havenhill or at his behest, Petitioner claims that Respondent is liable for outstanding bills from Spring Grove Physical Medicine for service from July 13, 2009 through September 4, 2009 and McHenry County Orthopedics from February 26, 2009 through November 6, 2009. *See* AX1 addendum, PX13, PX19. Thus, the Arbitrator awards the reasonable and necessary medical bills incurred by Petitioner at McHenry Orthopedics, excluding a $25 subpoena fee[4], and Spring Grove Physical Medicine related to treatment of

[4] PX13 at 647.

Petitioner's right hand/wrist and submitted in Petitioner's Exhibits 13 and 19 for the dates of treatment identified in the addendum to AX1 to be paid by Respondent as provided in Sections 8(a) and 8.2 of the Act.

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

In light of the causal connection analysis explained above, the Arbitrator addresses Petitioner's claim that he is entitled to temporary total disability and maintenance benefits. First, Petitioner claims that he is entitled to temporary total disability benefits for the period beginning June 24, 2009 through September 13, 2009 and April 7, 2010 through December 27, 2010.

While Petitioner testified that he was released to light duty work on December 29, 2008, no such restrictions are noted by Dr. Devaney or contained in the Orchard Medical Center's records. Moreover, no evidence was presented that Petitioner submitted any such light duty work restrictions to Respondent. Similarly, no light duty work restrictions are contained in the medical records until Petitioner's first right hand surgery with Dr. Havenhill on June 25, 2009, although the Arbitrator notes that Petitioner did undergo preoperative testing on June 24, 2009 as required by Dr. Havenhill. Then, Petitioner was either placed off work or on light duty restrictions by Dr. Havenhill until September 9, 2009 when Dr. Havenhill released Petitioner to full duty work.

Petitioner returned to Dr. Havenhill on October 21, 2009, but Dr. Havenhill did not impose any work restrictions at that time. On November 6, 2009, Petitioner returned to Dr. Havenhill and he imposed work restrictions, however, it appears that he only did so at Petitioner's request. Again, the Arbitrator finds that Petitioner's testimony at trial was not credible and no testimony was proffered by Dr. Havenhill on any matter. Moreover, the record reflects that Dr. Havenhill offered Petitioner a cortisone injection which he refused and that Dr. Havenhill again recommended that Petitioner should see a rheumatologist, which he failed to do. In the Arbitrator's view, Petitioner's lack of credibility and refusal to follow his physician's recommendations bears on whether the light duty restrictions issued by Dr. Havenhill on November 6, 2009 were imposed merely due to Petitioner's request even after his condition had stabilized or because Petitioner's medical condition had truly worsened as a result of his injury at work. In light of the record as a whole, the Arbitrator finds that Petitioner has established that he was temporarily totally disabled from June 24, 2009 through September 9, 2009.

Second, Petitioner claims that he is entitled to maintenance benefits for the period beginning December 28, 2010 through February 8, 2011 and again from July 3, 2011 through March 11, 2013 (the date of hearing). The Arbitrator notes that Petitioner does not assert any legal basis on which he is entitled to maintenance benefits for the period beginning on December 28, 2010 through February 8, 2011. The Arbitrator considers that Petitioner has waived this argument. Notwithstanding, in light of Dr. Havenhill's full duty release of Petitioner on September 9, 2009, the persuasive opinions rendered by Dr. Carroll, and (notwithstanding Dr. Carroll's opinions) Dr. Vender's full duty release of Petitioner with regard to the right hand/wrist on December 27, 2010, the Arbitrator finds that Petitioner has failed to prove his entitlement to any maintenance benefits as claimed.

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

Based on the record as a whole, reflecting that Petitioner sustained a right hand contusion requiring surgery for right wrist fourth dorsal extensor compartment tenosynovitis and physical therapy followed by a full duty release approximately 2 ½ months later, the Arbitrator finds that Petitioner has established permanent partial disability to the extent of 15% loss of use of the right hand pursuant to Section 8(e).

STATE OF ILLINOIS)
) SS.
COUNTY OF KANE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Mardy Jakubauskas,

Petitioner,

vs.

NO: 10WC 9942

15IWCC0075

Elgin Fire Department,

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 vocational rehabilitation, maintenance, 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 May 5, 2014, 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: JAN 2 9 2015

David L. Gore

Mario Basurto

Stephen Mathis

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

JAKUBAUSKAS, MARDY
Employee/Petitioner

Case# **10WC009942**

15IWCC0075

ELGIN FIRE DEPARTMENT
Employer/Respondent

On 5/5/2014, an arbitration decision on this case 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:

0247 HANNIGAN & BOTHA LTD
KEVIN BOTHA ESQ
505 E HAWLEY ST SUITE 240
MUNDELEIN, IL 60060

0078 BRADY & JENSEN LLP
FRED BEER
2425 ROYAL BLVD
ELGIN, IL 60123

STATE OF ILLINOIS)
)SS.
COUNTY OF KANE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Mardy Jakubauskas
Employee/Petitioner

v.

Elgin Fire Department
Employer/Respondent

Case # **10 WC 09942**

Consolidated cases:
15IWCC0075

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gerald Granada**, Arbitrator of the Commission, in the city of **City of Geneva**, on **March 19, 2014** After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

15IWCC0075

FINDINGS

On the date of accident, **1/24/10**, 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 not*** causally related to the accident.

In the year preceding the injury, Petitioner earned **$81,163.16**; the average weekly wage was **$1,560.83**.

On the date of accident, Petitioner was **46** years of age, ***married*** with **0** dependent children.

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

Respondent shall be given a credit of **$39,395.22** for TTD, $ for TPD, $ for maintenance, and $ for other benefits, for a total credit of $.

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

ORDER

Petitioner failed to meet her burden of proof regarding the issue of causation. Therefore Petitioner's claim for maintenance and vocational rehabilitation is denied.

The Petition for Penalties and Attorney fees is denied.

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $450.00 to Dr. Antonio Yuk, and $5,215.00 to Gregory Cook, P.C., as provided in Sections 8(a) and 8.2 of the Act. Respondent shall be given a credit for any medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

In no instance shall this award be a bar to subsequent hearing and determination of 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

4/22/14
Date

MAY 5 - 2014

FINDINGS OF FACT

Petitioner testified that he started working for respondent as a firefighter on October 17, 1994 and years later became a paramedic.

From April 8, 2009 through November 18, 2009, petitioner underwent chiropractic treatment for low back pain with Dr. Gregory B Cook, D.C. (PX2). Petitioner testified that in April 2009, Dr. Cook ordered her not to work due to back problems. He released her to go back to work on May 4, 2009.

Since on or about the start of her employment with respondent on October 17, 1994, petitioner also treated with a psychiatrist Dr. Shapiro for stress at work and attention deficit disorder and thereafter treated with Dr.Waliuddin when he purchased the Valley Psychiatry & Counseling practice from Dr. Shapiro. (RX 6, 9). Both doctors prescribed medication including but not limited to "chill pills".

On December 22, 2009, petitioner treated with Dr. Waliuddin for stress related to work. She was written up for everything and had difficulty focusing at work, poor concentration, and on and off depression. She had work related anxiety.

On January 24, 2010, the petitioner was engaged in fire fighting activities at the scene of a house fire. She was spraying water, slipped and fell on her left elbow, twisted her back and felt pain in the lower left portion of her back. (PX 13, RX 13). She did not work on January 27 and 28, 2010.

On January 28, 2010, she treated with Dr. Waliuddin and informed him that she was falling asleep during work hours. (RX 6). She was being written up for falling asleep and she was not able to handle the stress at work. He diagnosed work related stress and increased her medication and ordered a sleep study. Petitioner also treated with Dr. Waliuddin for work-related stress on March 9 and 25, 2010 when she reported that she felt stressed out thinking about going back to work.

From January 29, 2010 through October 20, 2010, March 23 and 28, 2011, and July 12, 2011, petitioner treated with Dr. Cook primarily for low back pain on her left side and other conditions. (PX 1). Dr. Cook issued work status reports indicating petitioner was unable to work on January 29, 2010, February 8, 15, 17, 24, 2010, and March 3, 10, 2010. Her condition improved with chiropractic treatment to similar fluctuating pain levels that she had prior to January 24, 2010. On August 4, 2010, Dr. Cook referred petitioner for an orthopedic exam.

On March 11, 2010, Dr. Mark N. Levin, M.D. of Barrington Orthopedic Specialists examined petitioner and reviewed her records and x-rays at the request of the respondent. (RX 1). Her primary complaints were on the left side of her low back. The January 29, 2010 x-rays showed what appeared to be a chronic minimal thoracic scoliosis and possibly very minimal Grade 1 anterolisthesis, L4 on L5. The March 11, 2010 lumbosacral x-rays showed that the bony architecture was normal. There was no evidence of any anterolisthesis. Dr. Levin did not find the exact pathology for her subjective complaints of pain that were directly related to her accident on January 24, 2010. She should be more functional and able to do activities. He recommended a baseline functional capacity evaluation and did not feel any additional chiropractic treatment would aid petitioner for her subjective complaints of pain. He ordered that she should be capable of working in a light-duty position in an office setting with the ability to sit or stand as needed for a 48 hour day five days a week.

On March 18, 2010, petitioner underwent a functional capacity evaluation. (PX3). Petitioner did not meet all of the functional demands for her firefighter/paramedic position. The therapist opined that she may benefit from work hardening/work conditioning program for improved flexibility, trunk and lower extremity strength, and overall activity tolerance.

On April 2, 2010, Dr. Levin examined the March 18, 2010 FCE and recommended that petitioner undergo work conditioning/work hardening five days a week for 3 to 4 weeks and be re-assessed with a new FCE to see if she could do her normal job.

From June 1, 2010 through July 1, 2010, petitioner underwent 20 sessions of work hardening at Centegra Health System. (PX 7). She continued to experience low back pain and did not meet all of the physical requirements of her job. She was functioning at a medium heavy level. The plan was to continue work hardening program or her physician's other instructions.

On July 8, 2010, Dr. Levin examined petitioner for a reevaluation and reviewed the work hardening records at the request of respondent. The work hardening helped petitioner's strength but she was still not able to do her job. In regard to her continued intermittent left side low back discomfort, Dr. Levin recommended an MRI of the lumbar spine.

On July 12, 2010, petitioner underwent an MRI of the lumbar spine and on July 15, 2010 Dr. Levin review the MRI. There was some generalized disc bulging. There was a slight finding at upper limits of the MRI at T11/12 of a protrusion to the right side. The petitioner's symptoms were on the left side of her back. For completeness, he recommended a thoracic MRI.

On July 27, 2010, petitioner underwent an MRI of the thoracic spine and on August 3, 2010, Dr. Levin reviewed the MRI. There was a right-sided disc herniation at approximately the T12–L1 level. It compressed the thecal sac but was to the right side. However, the petitioner's symptoms were mostly in the left lumbar area. With this right sided disc herniation, it was highly unlikely that it was causing the left-sided symptoms. Dr. Levin opined that he should attempt an epidural steroid injection and work light duty. If she did not get any improvement with the epidural, then EMG studies could be performed to see if there was any significance to the disc pathology.

On August 5, 2010, petitioner was examined by neurologist, Dr. Antonio C. Yuk, M.D. pursuant to the referral of Dr. Cook. (PX2). She still had back pain but there was improvement in her tolerance to more physical activity. He reviewed her MRI films. The most prominent MRI finding of a right-sided T11-12 disc herniation did not correlate well with her principal complaint of left sided paralumbar spine pain. There were no specific neurological symptoms or findings that suggest that the T11–12 disc protrusion was causing a serious problem. He did not recommend any operative procedure for this finding. It was possible that some of her pain was sustained by the facet arthroplathy seen at L4–L5. He recommended referral to pain management to consider epidural steroid injections at T12 and facet blocks at L4–L5. She could perform a light work with no lifting greater than 20 pounds.

On August 25, 2010, Dr. N. Ravishankar, M.D. of the Fox Valley Pain Center examined petitioner and administered a targeted lumbar epidural injection at the L4-L5 level on August 31, 2010. (PX2).

On August 26, 2010, petitioner treated with Dr. Waliuddin and stated that she had a psychological evaluation and was diagnosed having bipolar disorder type II. He diagnosed work related stress and recommended that she continue her current medication management.

On September 23, 2010, Dr. Ravishankar re-examined petitioner. She had no relief of her symptoms since her epidural steroid injection and still had low back pain and pain in her left groin and left thigh. She was active and was recently doing yard work. He administered a repeat epidural steroid injection at L4–L5. No sensory or motor block was noted. On October 18, 2010, he recommended a third epidural injection, but petitioner testified that she declined to undergo the third epidural injection because the first two injections gave her a very bad aches in her legs when she sat.

On October 8, 2010, Dr. Jonathan S. Citow, M.D. of Lake County Neurosurgery examined petitioner, her medical records and diagnostic films at the respondent's request. (RX 2). His office also took lumbar x-rays that day which confirmed there was no gross instability. He opined that she suffered a lumbar strain on January 24, 2010 which resolved by October 8, 2010, her condition did not require any further treatment, and she should be able to return to work full duty without restrictions since she had no specific pathology of any consequence.

On October 18, 2010, petitioner began working light duty office work at the respondent doing filing of documents.

On October 28, 2010, Dr. Yuk re-examined petitioner and recommended a functional capacity evaluation and that she remain on light duty.

On November 17, 2010, petitioner was working light duty filing papers and organizing them into different drawers. Fire Department Chief William Baker notified petitioner that she was scheduled for a re-orientation on November 22, 2010 and that her light duty assignment would terminate on November 21, 2010.

On November 18, 2010, petitioner was filing and could not move the files anymore because of back pain. (PX9, RX 8). She notified Paul Hurley and others that she could no longer file. She sought treatment at Sherman Family Healthcare for chronic back pain. (PX 6).

On November 22, 2010, petitioner did not return to respondent to attend the firefighter -paramedic re-orientation.

On November 24, 2010, Dr. Yuk re-examined petitioner. Petitioner notified him of the November 18, 2010 filing incident. Dr. Yuk conducted a SLR (straight leg raise) test which was negative, no focal weakness or deep tendon reflex change in upper or lower extremities. He issued a restriction note indicating that petitioner may attempt to work the re-orientation program. (PX 2).

Petitioner did not attempt to work the re-orientation program after November 24, 2010 until January 16, 2012 as stated below.

On December 10, 2010, Dr. Citow re-examined petitioner regarding the November 18, 2010 incident at the request of respondent. (RX 2). His diagnosis remained lumbar strain. The November 18, 2010 incident was not a new injury but exacerbation of an old injury. She had a lumbar strain relating to the original January 24, 2010 incident but he did not see significant pathology that should cause her to have such long-standing disability. She

could return to full duty as a firefighter/paramedic immediately. He recommended a functional capacity evaluation. No additional treatment was indicated and she was at maximum medical improvement.

On January 6, 2011, Dr. Yuk recommended a functional capacity evaluation.

On January 18, 2011, petitioner underwent a functional capacity evaluation at SCORE Industrial Rehabilitation of Sherman Health. She did not meet all of her functional job demands as a firefighter/paramedic. (PX 2). She met the requirements of light physical demand level for all lifting/carrying activities.

On February 4, 2011 and March 2, 2011, Dr. Citow reviewed the FCE and his prior IME reports and opined that in relation to her January 24, 2010 accident, she suffered a lumbar strain that should have resolved, she was at maximum medical improvement and could return to work full duty without restrictions. To the extent that her chronic back pain prevented her from working as a firefighter/paramedic, her chronic back pain was not due to the January 24, 2010 incident.

On March 31, 2011, Dr. Yuk reviewed the January 18, 2011 FCE. He stated that petitioner had been in a chronic back pain state of ill-being since her January 24, 2010 accident. He could not expect additional treatment to substantially change her condition. She reached maximum medical improvement with a permanent restriction to light physical work pursuant to her FCE. Dr. Yuk did not opine whether her chronic back condition since January 24, 2010 was caused or aggravated by the January 24, 2010 accident or a continuation of chronic back pain prior to the January 24, 2010 accident.

On February 24, 2011, petitioner underwent a partial hysterectomy and bladder surgery with Dr. Humberto Lamoutte, M.D. at Women's Healthcare Center. (RX 3–5). On April 21, 2011, Dr. Lamoutte issued a note indicating that petitioner was physically healthy and able to return to work on April 21, 2011. (RX 4-5).

On April 27, 2011, May 18, 2011, and June 14, 2011, Dr. Waliuddin examined petitioner and prepared medical certification employee's serious health condition reports pursuant to the Family and Medical Leave Act opining that petitioner was unable to function in any capacity from April 27, 2011 through July 20, 2011 due to depressed mood, fatigue, poor concentration, anxiety, panic attacks, insomnia, and lack of motivation. Her condition would cause episodic flare–ups periodically preventing her from performing her job functions.

On November 1, 2011, Dr. Waliuddin examined petitioner and issued a note certifying that petitioner was doing well and could resume her duties with no limitations starting on November 3, 2011. (RX 9).

On November 3, 2011, petitioner provided the Dr. Waliuddin November 1, 2011 note and her own note to Fire Chief Fahy indicating she was ready to return to work per the advice of Dr. Citow. (RX 9).

From November 11, 2011 through January 15, 2012, petitioner worked light duty at the respondent. (RX 10-11).

Petitioner agreed to return to work full duty and attend the Winter Firefighter Academy re-orientation from January 16 through March 16, 2012. The respondent paid for the academy. (RX 12).

On January 16, 2012, petitioner attended her first day at the academy and injured her right heel while jumping in the push-up position and sprinting. She never had this pain in her right heel before January 16, 2012. (PX 14).

Petitioner testified that on January 20, 2012, she was jogging and doing various exercises at the academy and noticed a stabbing pain in her right heel again and a pulling pain in her right hip. (PX 15). Petitioner sought treatment that day at Huntley Immediate Care. (PX 4). The records indicate she informed the doctor that she had been doing lots of calisthenics and vigorous physical activity at the academy and had right heel pain and left heel pain. An x-ray performed of the right heel showed a right heel spur. The impression was 1. Right heel spur/pain. 2. Left hip pain. The doctors plan was she should rest and ice the right heel, take Motrin, use gel heel inserts as cushions and referred her to a podiatrist. Petitioner testified the doctor referred her to a podiatrist but did not take her off work.

On January 24, 2012, Dr. Kevin S. Gavin, DPM of Algonquin Foot & Ankle Institute examined petitioner. (PX 5). She complained of right heel pain present at all times but worst upon rising in the morning and with prolonged standing. He assessed plantar fasciitis with infra calcaneal spur right foot. He recommended Medrol dosepak, strapping, ice and custom molded orthotics. He completed a note indicating she could work with no restrictions. (RX 13).

On January 25, 2012, petitioner returned to the academy.

On January 27, 2012, Dr. Gavin re-examined petitioner and administered a diagnostic ultrasound of her right foot. Plantar fasciitis was confirmed on the ultrasound. She reported that she attempted to run on January, 26 2012 during firefighter training and experienced immediate sharp pain in her right heel. He performed casting for orthotics and recommended a cortisone injection, but she would need to postpone her training until she had time to recover from her current heel condition.

On January 31, 2012, petitioner had another incident at the academy. The petitioner did not return to the academy after January 31, 2012.

On February 1, 2012, petitioner sought treatment at Sherman Hospital. (PX 6). The records indicate her chief complaint was left thigh and groin injury sustained on January 31, 2012 at work. She was picking a hose from the ground, fell forward and felt sudden pain in the left groin and inner proximal left thigh area. She also felt stiffness in the low back. Upon exam, she reported discomfort on internal rotation of the left hip and pain in the left groin when lifting the leg actively. The examination of her spine did not reveal any localized tenderness over the spine. There was mild tenderness over the paralumbar area, and movement of the lumbar spine was mildly to moderately limited because of stiffness and discomfort. The impression was 1. Acute left groin strain. 2 Low back pain. The plan was a prescription of Naproxen and Tylenol and modified duty at work. Petitioner testified that the modifications were no lifting, pushing, pulling or climbing.

On February 6, 2012, a doctor at Sherman Health Benefit Manager examined petitioner. (PX 6). The records indicate she complained of mild left groin pain. She did not complain of any back stiffness, discomfort or pain. The impression was left groin strain. No work restriction was issued.

On February 22, 2012, petitioner received a notice from the respondent that it terminated her for not being able to finish the academy, not keeping up her paramedic training, and other reasons.

On February 27, 2012, Dr. Gavin re-examined petitioner for chief complaint of right heel pain. She only had slight improvement with oral Naproxen and strapping. She still experienced significant pain with any attempts at normal standing and walking. She also had ongoing problems with the recurrent bunion deformity in her right

foot and would like to schedule a surgical consultation to discuss revision surgery. The assessment was plantar fasciitis right foot. He fitted her with new custom molded orthotics and strongly advised against using orthotics for any type of impact sports activity until after they were tolerated full-time all day for normal walking. He recommended fabrication of a night splint, future physical therapy, diagnostic ultrasound with guided cortisone injection. Surgical intervention may be necessary in the future. She was to schedule a surgical consultation to discuss her recurrent bunion condition.

On March 26, 2012, Dr. Gavin re-examined petitioner. She still had ongoing problems with chronic right heel pain. She also had problems with recurrent bunion deformity on her right foot which had been causing increasing pain and difficulty in all types of shoe gear for several months. They discussed surgical correction of her bunion. For the heel, he performed an ultrasound guided cortisone injection.

On May 31, 2012, Dr. Gavin re-examined petitioner. She had severe recurrent right heel pain. He performed a repeat cortisone injection.

On October 27, 2011, petitioner filed an application for in the line of duty disability benefits with the Elgin Firefighters Pension Fund ("the Fund") pursuant to the Illinois Pension Code (40 ILCS 5/4 – 110) in connection with the January 24, 2010 accident. (RX 19). Her attorney for the disability application is Thomas W. Duda.

On March 1, 2013, Attorney Duda sent an email to the attorney for the Fund, Cary Collins, (RX 20) admitting on behalf of the petitioner that he and petitioner's workers'compensation attorney Mr. Botha:

> "both strongly believe that a huge element of Ms. Jakubauskas' disability is psychological. Therefore, in reference to your inquiry I would suggest that the Pension Board select the three (3) specialties – psychiatry/psychology, orthopeadic surgery and finally neurosurgery. The last treating doctor to render and (sic) opinion about Ms. Jakubauskas for the Petitioner was a neurosurgeon, for the Respondent an orthopaedic surgeon. Ms Jakubauskas has a significant psychological component in her disability. Again, Mr. Botha and I both feel strongly that a psychologist/psychiatrist should be part of the mix."

On May 13, 2013, Dr. Erc Ostrov, J.D., PhD., ABPP of Forensic Psychology Associates evaluated petitioner, administered psychological tests to petitioner, and reviewed her treatment records at the request of the Fund and Attorney Duda. He prepared a report dated June 4, 2013. (RX 14). Petitioner informed Dr. Ostrov of her daily activities but did not mention doing any periodic job search. (RX 14, p. 3). She still had problems with the heel spur on her foot. She reported she was suffering from depression, anxiety and problems thinking clearly. These problems were so bad she was unable to meet any of her responsibilities. (RX 14, p. 4). She probably could do the firefighter/paramedic work physically at that time. (RX 14, p. 7) The clinical scale test scores suggested significant symptoms of depression, anxiety, affective instability, stress, and difficulty thinking clearly. (RX 14, p.7) Dr. Ostrov opined and concluded that petitioner is suffering from unstable mood, difficulty paying attention, and ADHD. Her psychological condition precluded her from being able to function as a firefighter. Her limitations are psychological or emotional in nature, not physical. There is no clear or compelling evidence that her psychological problems are the result of her service as a firefighter. (RX 14, p. 8-9).

On December 2, 2013, psychiatrist Dr.Stevan Weine, M.D. examined and interviewed petitioner and reviewed her records including but not limited to the March 1, 2013 Attorney Duda email (RX 20) stating that her attorneys stated that "a huge element of Ms. Jakubauskas' disability is psychological." Dr. Weine prepared a certificate of disability dated December 2, 2013 and a report dated December 8, 2013. (RX 18). She reported current symptoms of anxiety, anger, depression, disgust, hurt, and shock. She denied being in chronic pain, but reported occasional "aches and pains" in her lower back. (RX 18, p.3). Dr. Weine opined that petitioner currently meets diagnostic criteria for Major Depressive Disorder, Recurrent, Partially Treated, Attention Deficit Hyperactivity Disorder, and Personality Disorder NOS (enduring maladaptive patterns of behavior, cognition and inner experience). She has trends of instability, gloom, anger, interpersonal conflict, and negativity that don't appear to meet the diagnostic criteria of the only identified personality disorder. The history and examination indicate that these conditions have been present since it least 2004, and very likely earlier. (RX18, p. 6-7). Her psychological condition did not create any physical injury limitations, but her psychological symptoms do not allow her to perform full and unrestricted firefighter duties. Her attention, depression, and personality symptoms would interfere with her performance as a firefighter in terms of motivation, attitude, response time, teamwork, and judgment. She would present a risk to firefighters, the public and to herself. Even if she were to receive adequate treatment, it is highly unlikely that she would recover to a degree that she would be fit for fulltime firefighter duty. These psychiatric medical problems were not related to her firefighting service. (RX18, p. 7-8).

On December 9, 2013, Dr. John Stamelos, M.D. of Buffalo Grove Orthopaedic Associates examined petitioner and her records at the request of the Fund and Attorney Duda. (RX 17). She reported that she currently did not have back pain, but did have some intermittent back discomfort that has not occurred very often over the last year. (RX 17, p. 7). Upon exam and an x-ray taken on December 9, 2013, petitioner had significant hyperlordosis posturing of her low back. She could flex fully and extend past neutral without discomfort. Lateral movement was unrestricted. Other back tests were negative and she could get up from a lying position to a sitting position without difficulty. There was no evidence of any abnormal pain behavior while she was sitting during the extensive lengthy history. He diagnosed chronic back pain related to her hyperlordosis which was related to facet overload. He did not opine whether the January 24, 2010 accident caused or aggravated her hyperlordosis. (RX 17, p. 8-10).

On January 13, 2014, neurologist Dr. Elizabeth S. Kessler, M. D. examined petitioner and her records at the request of the Fund and Attorney Duda. She prepared a report and physician certificate of disability dated February 3, 2014. (RX 16). Petitioner reported that she had that low back pain for years prior to the January 24, 2010 accident. She was fine until two days prior to the accident when her low back started aching. She was unable to work as a firefighter/paramedic due to her foot. (RX 16. p. 4) Her low back pain was inconsistent and she did not have low back pain daily. She had no pain down either of her legs. Two weeks after the accident she had numbness in her right second toe but this resolved. She had no other numbness or tingling and no weakness. (RX 16, p.3). When discussing her daily activities, she did not mention any regular periodic job search. Upon exam, she was negative bilaterally upon leg raising tests. She could flex forward while standing 90 degrees. There were no symptoms with axial rotation. There was no reported tenderness to palpation over the cervical, thoracic or lumbosacral paraspinal areas and no muscle spasm was palpable. Her muscles strength and tone were normal throughout both upper and lower extremities. There was a slight, fine, postural tremor of the upper extremities. She reported decreased vibratory sensation over the right little toe. There were no reported deficits to pin or proprioception. She was able to perform heal-to-knee and rapid alternating movements bilaterally normally. Her gait was normal as was her ability to walk on her heels, tows and tandem. (RX 16, p.4-5). Dr. Kessler opined that petitioner sustained a low back muscle strain on January 24, 2010. This type of muscle

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strain may cause muscle spasm, pain and limited mobility but will usually resolve within one or two weeks although it may take up to about a month. She may have also sustained a transient strain to her left elbow. There was no evidence from a neurological point of view that petitioner sustained any other injuries in the January 24, 2010 accident. There was no objective evidence of any other injury that she sustained to her low back or any physical pathology that would correlate with her various, persistent and variable reported symptoms. She should have been able to return to work full duty following the January 24, 2010 accident. As of January 13, 2014, petitioner was not certified as permanently disabled from firefighter service regarding low back or any neurological injuries. (RX 16, certificate of disability and p. 10).

From February 24, 2012 through February 14, 2014, petitioner conducted a job search, but she was unable to obtain a job. (PX 10, 12). She did obtain unemployment from 2012 through 2013.

Petitioner testified that as of March 19, 2014 she had difficulty standing and going for long walks. It would take about 45 minutes for her back to start aching. She would split up her daily activities. She would wake up intermittently but did not know why she would wake up. She would take Ibuprofen for her back swelling. She could no longer do recreational activities with her friends and kids such as volleyball, kickball, soccer. Frisbee, and softball.

At the March 19, 2014 hearing, petitioner's counsel informed the arbitrator that petitioner was requesting penalties and attorneys fees under sections 19(K), 19(l) and 16 for failure to provide vocational rehabilitation and maintenance benefits. Respondent's counsel notified the Arbitrator that petitioner did not file a motion for penalties and or attorneys fees and did not notify respondent of the same prior to March 19, 2014. Petitioner previously filed a notice of a section 8(a) motion to compel vocational rehabilitation and request for hearing under section 19 (b) with no motions or petitions attached. On March 5, 2014, respondent filed a response to petitioner's motion stating that no motion was attached to the notice of motion and request for hearing and denying that vocational rehabilitation was appropriate.

The parties agreed that the respondent shall pay any outstanding medical bills pursuant to the medical fee schedule that are related to the accident and that it shall receive a credit for any prior payments.

CONCLUSIONS OF LAW

1. The Arbitrator finds that the Petitioner failed to meet her burden of proof on the issue of causation. The Arbitrator finds that the petitioner previously achieved maximum medical improvement in 2010. Specifically, petitioner had pre-existing low back problems and treated with Dr. Cook in April 2009 when he ordered her not to work until he released her to work on May 4, 2009. She informed Dr. Kessler that her low back started aching two days before January 24, 2010. By February 18, 2010, her pain level of 5/10 reported to Dr. Cook was similar to her fluctuating pain level prior to January 24, 2010. Drs. Levin and Yuk opined that petitioner's complaints in 2010 after her accident were primarily on the left side of her low back, but that the findings of the MRIs of her lumbar and thoracic spine did not correlate with her left side low back complaints. Drs. Levin, Citow, and Kessler opined that petitioner sustained a low back sprain/strain that should have resolved within a few months after the January 24, 2010 accident. Dr. Yuk did not specifically opine whether petitioner's chronic back condition was caused or aggravated by the January 24, 2010 accident. Dr. Stamelos diagnosed chronic back pain related to her hyperlordosis and facet overload, but did not opine whether the January 24, 2010 accident caused or aggravated her hyperlordosis on a long term basis. Prior to January 24, 2010, petitioner

reported to Dr. Cook that her low back symptoms were exacerbated by normal activities of daily living and lifting.

The Arbitrator further notes that the evidence casts a shadow of doubt on the Petitioner's credibility. Although Petitioner claims that her inability to return to work is in no way related to her psychological condition, the medical evidence adduced from her claim for duty disability pension benefits paints an entirely different picture. The psychological experts all point to the Petitioner's psychological conditions as being the basis behind her inability to return to work, and not her physical injuries. Accordingly, the Arbitrator finds that the Petitioner's current condition of ill-being is not causally related to her accident from January 24, 2010.

2. Based on the Arbitrator's findings regarding the issue of causation, the Petitioner's claims for maintenance and vocational rehabilitation are denied.

3. Given the issues in dispute and the Arbitrator's findings above, the Petition for Penalties and Attorney's Fees is denied.

4. With regard to the issue of medical expenses, the Arbitrator finds that the Petitioner's medical treatment has been reasonable and necessary and there was no evidence presented to question any of the treatment or the medical expenses. As such, Petitioner is awarded all related medical expenses, including those of Dr. Yuk ($450.00) and Dr. Cook ($5,215.00) subject to the Fee Schedule and in accordance with Sections 8(a) and 8.2 of the Act. Respondent shall be given a credit for any 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.

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

Dennis Sloniker,
Petitioner,

vs.

NO: 11WC 14983

15IWCC0076

Aspen Construction,
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 wage differential and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 21, 2013, is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $17,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JAN 2 9 2015
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CJD/jrc
049

Charles J. DeVriendt

Daniel R. Donohoo

DISSENT

I respectfully dissent from the majority. In this claim the only issue before the Commission is the appropriate date to determine the wage differential. The majority affirmed the determination of the Arbitrator that the there were two different applicable wage differentials; one applying as of the date Petitioner obtained suitable employment and another from the date of the arbitration hearing which would be in effect thereafter. The Arbitrator/Commission decision was based on the fact that a union contract in effect at the time scheduled a raise in Petitioner's previous job which became effective between the date Petitioner began his new employment and the date of arbitration. I believe the wage differential as of the date Petitioner began his suitable employment should have been applicable throughout.

In *United Airlines v. Illinois Workers' Compensation Commission*, 991 N.E.2d 458 (1st Dist. WC App. Div. 2013), the Appellate Court rejected the employer's attempt to impose a sliding scale wage differential based on changes in union contracts after the date of the arbitration hearing. Under the employer's recommended calculation the wage differential would be reduced over time as the new job wage increases would be greater than those in the previous job. It was in that context that the Appellate Court held that the wage differential at the date of arbitration rather than speculative conjecture about future relative earnings should be applied. In *United Airlines*, the wage differential as of the date of the new employment and the date of arbitration were the same. Therefore, the relative appropriateness of those dates to determined wage differential was moot. In my opinion, the *United Airlines* decision stands for the proposition that the date of arbitration is the **latest** date upon which a wage differential can be based not the only date. *See, Smith v. Industrial Commission*, 388 All. App. 3d 260 (3rd Dist 1999).

In the claim now before the Commission, the claimant obtained suitable employment on August 15, 2012 and the claim was arbitrated on July 23, 2013. While there is no allegation that the claimant purposefully delayed the proceedings in order to increase his wage differential, requiring the use of the date of arbitration to determine wage differential would often provide incentive for such delay, especially in cases in which union contracts with scheduled raises are in effect. The Commission should not encourage such possible manipulation. In addition, it should be noted that using the later date of arbitration would inure to the benefit of the claimant rather than to the employer in virtually every instance, and it is not clear that the later date would be applied at all if it accrued to the benefit of the employer. I do not believe such a one-sided rule is fair to employers. Finally, the *United Airlines* court stressed wage differential should not be based on speculation. I think it is inherently speculative to assume that a claimant would necessarily still be employed in the particular occupation he or she had prior to an accident on a date perhaps a year or more after the claimant began new employment.

For these reasons, I respectfully dissent.

Ruth W. White

Ruth W. White

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SLONIKER, DENNIS
Employee/Petitioner

Case# **11WC014983**

15IWCC0076

ASPEN CONSTRUCTION SYSTEMS INC
Employer/Respondent

On 10/21/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.15% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0021 REESE & REESE
RANDALL K REESE
979 N MAIN ST
ROCKFORD, IL 61103

2461 NYHAN BAMBRICK KINZIE & LOWRY PC
THOMAS J MALLERS
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602

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

Dennis Sloniker
Employee/Petitioner

v.

Aspen Construction Systems, Inc.
Employer/Respondent

Case # **11** WC **14983**

Consolidated cases: _____

15IWCC0076

An *Application for Adjustment 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 **Rockford**, on **7/23/13**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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 **Calculation of 8(d)(1) benefits.**

FINDINGS

On **2/22/10**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$60,099.71**; the average weekly wage was **$1,278.72**.

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, **$44,694.30** for maintenance, and **$23,478.35** for other benefits, for a total credit of **$68,172.65**.

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 $14,305.78, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner maintenance benefits of $852.48/week for 52-3/7 weeks, commencing 8/12/11 through 8/14/12, as provided in Section 8(a) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of: $532.61/week for 41-3/7 weeks, commencing 8/15/12 through 5/31/13, or $22,065.27; and $549.73/week for 7-4/7 weeks, commencing 6/1/13 through 7/23/13, or $4,162.24, because the injuries sustained caused a loss of earnings, as provided in Section 8(d)1 of the Act.

Respondent shall pay Petitioner permanent partial disability benefits, commencing 7/24/13, of $549.73/week for the duration of the disability, because the injuries sustained caused a loss of earnings, as provided in Section 8(d)1 of the Act.

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

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

Edward Lee
Signature of Arbitrator

10/17/13
Date

OCT 21 2013

Dennis Sloniker v. Aspen Construction Systems, Inc.
11 WC 14983

ADDENDUM TO PROPOSED ARBITRATOR'S DECISION

Findings of Fact:

The record reflects that this matter was previously tried on a 19(b) Petition on 8/11/11. An Arbitration Decision was filed with the Commission on 10/25/11 and received by Petitioner on 10/31/11. A copy of the 8/11/11 Decision is marked as Arbitrator's Exhibit #4. The 8/11/11 Award clearly indicates: "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." The Respondent only disputes the medical expenses since the previous trial on 8/11/11 and the calculation of Section 8(d)(1) benefits. The Respondent stipulates to an 8(d)(1) award. See Arb. Ex. 1.

The Petitioner testified that he had previously been determined, by his treating physician, to have reached maximum medical improvement (MMI) on or around 2/23/11. He had not yet been released from treatment by his doctors. Petitioner testified that he continued to treat with Dr. Keehn at Advanced Pain Management (Px. 1) for continued maintenance evaluations and refill of his prescription medications. Dr. Keehn also continued Petitioner's restricted work activity and continued his prescriptions of Fentanyl patches, Amitryptyline and over-the-counter medications of Ibuprofen and Naproxen. The Arbitrator finds Petitioner's testimony credible and unrebutted.

On 10/18/11, petitioner testified and the medical records (Px. 1) reflect that Petitioner was seen by Dr. Keehn for evaluation to monitor his medications and what, if any, impact they were having on his physical condition. Petitioner continued with significant pain complaints and Dr. Keehn continued his modified work activity, which restricted Petitioner from returning to work for the employer. Petitioner's prescriptions for Fentanyl and Amitryptyline were refilled.

On 10/25/11, Petitioner testified and the medical records (Px. 1) reflect that Petitioner's restrictions were continued.

On 11/9/11, Petitioner testified and the medical records (Px. 1) reflect that Dr. Keehn ordered a Functional Capacity Evaluation (FCE). Petitioner underwent the FCE on 11/28/11. (Px. 2). On 1/10/12, Petitioner was seen by Dr. Keehn, who agreed with the restrictions placed upon his activities by the FCE. Petitioner was permanently restricted from returning to his regular duty work activity as a foreman carpenter.

On 4/6/12, Petitioner testified and the medical records reflect that he followed up with Dr. Keehn. Petitioner noticed that he was having more pain down his leg and that his buttocks was numb. Dr. Keehn recommended an additional epidural steroid injection and refilled Petitioner's prescriptions. The injection was not obtained because of the risk of the side effects.

On 6/29/12, Petitioner testified and the medical records (Px. 1) reflect that he followed up with Dr. Keehn and continued to complain that he felt his condition was deteriorating. Dr. Keehn increased the dosage of Fentanyl from 75mg every three (3) days to 75mg every two (2) days. Dr. Keehn ordered a toxicology screen/blood test to assess the drug metabolism and the impact of the continued use of the drugs on the internal organs.

On 10/12/12, Petitioner testified and the medical records (Px. 1) reflect that he noticed that one of the side effects of the Fentanyl patches was sexual dysfunction. The increased dosage was not helping the pain any more than the lesser dosage and he was beginning to develop some sexual dysfunction. Dr. Keehn then reduced the Fentanyl dosage to 50mg every two (2) days. Petitioner was then asked to follow up in four (4) weeks time, instead of the normal three (3) months.

On 11/8/12, Petitioner testified and the medical records (Px. 1) reflect that he followed up with Dr. Keehn. Petitioner did not notice any increased pain with the reduction in the medication dosage. The prescriptions were renewed at the same level and he was to follow up in the standard three-month time frame.

On 1/31/13, Petitioner testified and the medical records (Px. 1) reflect that Dr. Keehn performed an examination, continued the prescription medications and scheduled a return appointment in April. Petitioner was seen on 4/25/13, an examination was performed and the prescriptions were refilled. The Arbitrator notes that Petitioner was wearing the Fentanyl patch at the time of trial and the Arbitrator had the opportunity to view the patch located on the right upper chest area. Petitioner also testified that he has a TENS unit that was prescribed by Dr. Keehn, which is used every day throughout the day at work and at home. The Arbitrator finds Petitioner's testimony credible and unrebutted.

Petitioner testified that he was last seen by Dr. Keehn on 7/18/13. His current restrictions were continued and his prescription medications were renewed. Petitioner is scheduled to follow up with Dr. Keehn on 10/20/13.

Petitioner testified that following the FCE on 11/28/11 he began to do a self-directed job search and kept records of his contacts. Petitioner's Exhibit #8 reflects Petitioner's job search records from January of 2012 through July of 2012. Petitioner testified that he conducted a good faith search in an effort to obtain alternate employment, but no offers of employment were made during that period.

Respondent did eventually initiate vocational rehabilitation and an initial assessment was obtained in March of 2012. However, Respondent did not assist in

Petitioner's job search. Respondent's vocational counsellor prepared a report (Px. 4) and identified certain jobs that he believed Petitioner should be able to return to work: retail sales at $9.48/hour; customer service sedentary work at $14.00/hour; and a driver/sales worker at $11.79/hour. The vocational counsellor also prepared a labor market survey. (Px. 5). The survey identified possible jobs that fit within Petitioner's qualifications. Petitioner testified that he contacted every potential employer that was listed on the labor market survey and was unable to secure employment. The Respondent also verified that they were unable to take Petitioner back to work. (Px. 6 & 7).

Petitioner testified that he continued his job search activity and interviewed with a carpet company, Coyle Carpet One. On Petitioner's own job search, Petitioner was offered a job as a Field Measurer at $14.00/hour for 40 hours per week. Petitioner accepted the position and notified the workers' compensation carrier. (Px. 10). His duties include going to customer's homes to measure flooring and drawing up a schematic of the installation. Petitioner has a laser-measure that attaches to a wall and measures the distance. Petitioner began his employment on 8/15/12. (Px. 11).

Petitioner testified that he continues to earn $14.00/hour and the employer has indicated that there will be no raises in the foreseeable future. The Arbitrator finds Petitioner's testimony credible and unrebutted.

Petitioner testified that at the time of this work accident he was a member of the Union and his wages were subject to Union scale. The parties agree that Petitioner averaged 34.2553 hours per week. Had Petitioner not been injured, he would have been paid at foreman wages. Petitioner testified that between 6/1/12 and 5/31/13 the foreman wages were $39.67/hour. (Px. 14). Petitioner testified that the Union scale for foremen for the period of 6/1/13 through 5/31/14 was $40.42/hour plus Health & Welfare and retirement benefits. (Px. 15). Petitioner testified that had he not been injured he would have continued to work in the position as a carpenter/foreman and continued to be a member of the Union, earning Union scale. The Arbitrator finds Petitioner's testimony credible and unrebutted.

Regarding the Arbitrator's finding (J): Has Respondent paid all appropriate charges for all reasonable and necessary medical services; the Arbitrator finds the following facts:

The Arbitrator adopts and incorporates all the above findings of fact into these findings.

The Arbitrator finds that there was no objection by the Respondent with regard to the reasonableness and necessity of the medical care and treatment. The record reflects that this matter was previously tried on a 19(b) Petition on 8/11/11. An Arbitration Decision was filed with the Commission on 10/25/11 and received by Petitioner on 10/31/11. A copy of the 8/11/11 Decision is marked as Arbitrator's Exhibit #4. The

8/11/11 Award clearly indicates: "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."

Despite the fact that the Respondent has stipulated that Petitioner's current condition of ill-being is causally connected to this injury and stipulated to an 8(d)(1) award, the Respondent disputes the medical bills since the previous trial on 8/11/11. See Arb. Ex. 1.

Petitioner entered into evidence a total medical bill exhibit of $14,305.78. (Px. 3A – 3F). Arbitrator's Exhibit 1 reflects that Respondent claims it paid $0.00 in medical bills through its group medical plan for which credit may be allowed under Section 8(j) of the Act.

Provider	PX	Date of Service	Amount
Advanced Pain Management	3A	10/18/11 – 4/25/13	$5,106.00
Dean Therapy Center	3B	11/28/11	$1,728.00
MedTox Laboratories	3C	6/29/12	$48.44
Prescriptions	3D		$5,323.11
EMPI, Inc. (TENS Unit)	3E	8/30/11	$902.03
IWP Prescriptions	3F	5/2/13, 6/6/13, 7/3/13	$1,198.20

			Total = $14,305.78

The Petitioner testified that he had previously been determined, by his treating physician, to have reached MMI on or around 2/23/11. However, he had not yet been released from treatment by his doctors. Petitioner testified that he continued to treat with Dr. Keehn at Advanced Pain Management (Px. 1) for continued maintenance evaluations and refill of his prescription medications. Dr. Keehn also continued Petitioner's restricted work activity and prescriptions of Fentanyl patches, Amitryptyline, a TENS Unit and over-the-counter medications of Ibuprofen and Naproxen. The Arbitrator finds Petitioner's testimony credible and unrebutted.

Petitioner is entitled to the medical expenses, pursuant to Section 8(a) and 8.2 of the Act. The Arbitrator therefore awards Petitioner's medical expenses in the amount of $14,305.78, pursuant to Section 8(a) and 8.2 of the Act.

Petitioner also testified that his last office visit with Dr. Keehn was 7/18/13 and that his maintenance medical visits will continue with his next scheduled appointment on 10/20/13.

Petitioner is entitled to payment of medical expenses for the 7/18/13 office visit, continuing maintenance, including but not limited to office visits, prescription medication, TENS Unit supplies and such other medical that is reasonable and necessary, pursuant to Section 8(a) and 8.2 of the Act.

Regarding the Arbitrator's finding (O): Calculation of 8(d)(1) benefits; the Arbitrator finds the following facts:

The Arbitrator adopts and incorporates all the above findings of fact into these findings.

Arbitrator's Exhibit 1 reflects that the parties stipulated to an 8(d)(1) award and the only issue is the calculation of the 8(d)(1) benefits.

The Respondent argues that the amount Petitioner would be able to earn in the full performance of his duties in the occupation at the time of the accident is determined as of the date that Petitioner reached maximum medical improvement (MMI) and not the date of the arbitration hearing. The Arbitrator agrees with Petitioner that the wage differential amount must be determined as of the date of the arbitration hearing.

Section 8(d)(1) provides, in relevant part, that a partially incapacitated employee shall:

> "receive compensation for the duration of his disability . . . equal to 66-2/3% of the difference between the average amount which he would be able to earn in the full performance of his duties in the occupation in which he was engaged at the time of the accident and the average amount which he is earning or is able to earn in some suitable employment or business after the accident." 820 ILCS 305/8(d)(1) (West 2006).

The Arbitrator notes that it is well established that the wage differential amount must be calculated based on the amount the claimant would have been able to earn **at the time of the arbitration hearing** if he were able to fully perform the duties of the occupation in which he was engaged at the time of his injury. *General Electric Co. v. Industrial Comm'n*, 144 Ill.App.3d 1003, 1013 (4th Dist. 1986); *Old Ben Coal Co. v. Industrial Comm'n*, 198 Ill.App.3d 485, 493 (5th Dist. 1990); *Greaney v. Industrial Comm'n*, 358 Ill.App.3d 1002, 1020 (1st Dist. 2005); *Morton's of Chicago v. Industrial Comm'n*, 366 Ill.App.3d 1056, 1061 (1st Dist. 2006); and most recently, although the opinion has not yet been released for publication, *United Airlines v. Illinois Workers' Comp. Comm'n*, 2013 WL 2404012 (1st Dist. 2013).

Petitioner testified that he has accepted a job as a Field Measurer at $14.00/hour for 40 hours per week. Petitioner began his employment on 8/15/12. (Px. 11). Petitioner testified that he continues to earn $14.00/hour and the employer has indicated that there will be no raises in the foreseeable future. Petitioner currently earns $560.00 per week. The Arbitrator finds Petitioner's testimony credible and unrebutted.

Petitioner testified that at the time of this work accident he was a member of the Union and his wages were subject to Union scale. The parties agree that Petitioner averaged 34.2553 hours per week. Had Petitioner not been injured, he would have been paid at foreman wages. Petitioner testified that between 6/1/12 and 5/31/13 the foreman

wages were $39.67/hour ($1,358.91/week). (Px. 14). Petitioner testified that the Union scale for foremen for the period of 6/1/13 through 5/31/14 is $40.42/hour ($1,384.60/week) plus Health & Welfare and retirement benefits. (Px. 15). Petitioner testified that had he not been injured he would have continued to work in the position as a carpenter/foreman and continued to be a member of the Union, earning Union scale. The Arbitrator finds Petitioner's testimony credible and unrebutted.

The Arbitrator finds that Petitioner is entitled to the following maintenance and 8(d)(1) benefits through the date of trial on 7/23/13:

Maintenance	Amount
8/12/11 through 8/14/12 (52-3/7 weeks @ $852.48)	$44,694.30

Section 8(d)(1) benefits

8/15/12 through 5/31/13 (41-3/7 weeks) $22,065.27

- $39.67/hr x 34.2553 hours = $1,358.91/week
- $1,358.91 - $560.00 = $798.91
- $798.91 x 2/3 = $532.61
- $532.61 x 41-3/7 weeks = $22,065.27

6/1/13 through 7/23/13 (7-4/7 weeks) $4,162.24

- $40.42/hr x 34.2553 hours = $1,384.60/week
- $1,384.60 - $560.00 = $824.60
- $824.60 x 2/3 = $549.73
- $549.73 x 7-4/7 weeks = $4,162.24

Total: $70,921.81

Respondent is given a credit of $44,694.30 in maintenance benefits and $23,478.35 in 8(d)(1) benefits, for a total of $68,172.65. Respondent owes Petitioner an underpayment of 8(d)(1) benefits in the amount of $2,749.16.

Respondent shall pay Petitioner permanent partial disability benefits, commencing 7/24/13, of $549.73/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)
) SS.
COUNTY OF)
WILLIAMSON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

CHERYL TEEL,
Petitioner,
vs. NO: 11WC 38510

STATE OF ILLINOIS/MENARD CORRECTIONAL CENTER,
Respondent,

15IWCC0077

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 issuesof accident, medical expenses, notice, temporary total disability, permanent partial disability, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 7, 2014, is hereby affirmed and adopted.

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

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

DATED: JAN 30 2015
MJB/bm
o-1/27/2015
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

TEEL, CHERYL
Employee/Petitioner

Case# **11WC038510**

15IWCC0077

SOI/MENARD CORRECTIONAL CENTER
Employer/Respondent

On 2/7/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.06% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

0502 ST EMPLOYMENT RETIREMENT SYSTEMS
2101 S VETERANS PARKWAY*
PO BOX 19255
SPRINGFIELD, IL 62794-9255

0558 ASSISTANT ATTORNEY GENERAL
AARON L WRIGHT
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

1350 CENTRAL MGMT SERVICES RISK MGMT
WORKERS' COMPENSATION CLAIMS
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

FEB 7 2014

KIMBERLY B. JANAS Secretary

15IWCC0077

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

Cheryl Teel
Employee/Petitioner

v.

State of Illinois/Menard Correctional Center
Employer/Respondent

Case # 11 WC 38510

Consolidated cases: n/a

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Herrin, on December 11, 2013. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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, 2011, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $55,180.50; the average weekly wage was $1,061.16.

On the date of accident, Petitioner was 64 years of age, married with 0 dependent child(ren).

Petitioner has received all reasonable and necessary medical services.

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

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

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

ORDER

Respondent shall pay reasonable and necessary medical services as identified in Petitioner's Exhibit 9, as provided in Sections 8(a) and 8.2 of the Act subject to the fee schedule. Respondent shall be given a credit for amounts paid for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $707.44 per week for one and one-seventh weeks (one and four-seventh weeks minus the three day waiting period) commencing August 16, 2012, through August 26, 2012, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $636.70 per week for 68.7 weeks because the injury sustained caused the 15% loss of use of the right arm and 15% loss of use of the right hand as provided in Section 8(e) of the Act.

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

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

William R. Gallagher, Arbitrator

February 3, 2014
Date

FEB 7 - 2014

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged she sustained a repetitive trauma injury arising out of and in the course of her employment for Respondent. The Application alleged a date of accident (manifestation) of February 22, 2011, and that Petitioner sustained repetitive trauma to both elbows and the right hand. Respondent disputed liability on the basis of accident, notice and causal relationship.

At the time the injury manifested itself, Petitioner had worked for Respondent for approximately 19 years as a Health Information Technician/Medical Records Supervisor. Petitioner testified in detail as to the requirements of her job. Menard Correctional Center has approximately 3,700 inmates, each of which has a medical chart. The health unit employs three physicians and two nurse practitioners. One of Petitioner's regular job duties was to prepare "call lines" which is a handwritten schedule of the inmates that the medical staff will see each day. The Petitioner will then type this information into a computer along with the appointment time and date as well as the physician/nurse practitioner the inmate will see.

After preparing the call lines, Petitioner had to pull the medical chart for each of the inmates that were scheduled to be seen. These charts are kept in an open shelving area and some of them are one inch to three inches thick. Petitioner testified that she would have to reach overhead on numerous occasions to retrieve these charts.

At the direction of Respondent, Petitioner's supervisor, Nikki Malley, prepared a Demands of the Job form in regard to Petitioner's job duties. This form indicated that Petitioner would use her hands for fine manipulation (typing/jobs that required good finger dexterity) for four to six hours per day. The form also indicated that Petitioner would use her hands for gross manipulation (grasping, twisting, handling) for two to four hours per day (Petitioner's Exhibit 7). Petitioner testified that these estimates were accurate and that she spent the majority of her work day keyboarding at a computer.

Over time, Petitioner began to experience symptoms in her right arm and hand. Specifically, Petitioner began to have what she described as pins and needles type feelings in the ring and little fingers of her right hand. She noticed the development of these symptoms while at work after typing. Petitioner's recollection of when she first started having the symptoms was sometime in either 2004 or 2005; however, Petitioner did not seek any medical attention until she was seen by Dr. James Chow, an orthopedic surgeon, on February 22, 2011.

Dr. Chow's record of February 22, 2011, indicated that Petitioner was a 64-year-old right hand dominant lady who worked in medical records for 18 years and did a lot of pulling charts, filing, computer work, etc. At the time of that initial visit with Dr. Chow, he referred her to Dr. Sajjan Nemani, who performed nerve conduction studies that same day. Dr. Chow's findings on clinical examination and the nerve conduction studies were both positive for bilateral ulnar nerve compression and mild carpal tunnel syndrome of the right hand. At that time, Dr. Chow recommended Petitioner have ulnar nerve compression and transposition surgeries performed on both elbows (Petitioner's Exhibits 2 and 3). Petitioner decided not to proceed with surgery at that time hoping that the symptoms would resolve on their own.

Petitioner reported this work-related condition to Respondent the following day, February 23, 2012. She prepared and signed a Workers' Compensation Notice of Injury form (Respondent's Exhibit 1).

At the direction of the Respondent, Petitioner was examined by Dr. Anthony Sudekum, a hand surgeon, on November 21, 2011. While Dr. Sudekum's report bears the date of November 21, 2011; however in his deposition testimony Dr. Sudekum acknowledged the report was not completed until sometime in June, 2012. In connection with his examination of Petitioner Dr. Sudekum reviewed medical treatment records, a job description and the Demands of the Job form. Dr. Sudekum opined that Petitioner's cubital tunnel and right carpal tunnel syndrome conditions were not causally related and that they were most likely due to other conditions including osteoarthritis of the hands, hypertension, cervical disc disease and coronary artery disease. He also opined that Petitioner's work activities could, in fact, be therapeutic and beneficial to her (Respondent's Exhibit 2).

Petitioner was seen again by Dr. Chow on June 28, 2012, and Petitioner advised Dr. Chow that her symptoms had worsened and that she was experiencing numbness/tingling in all of the fingers of both hands. Dr. Chow again referred Petitioner to Dr. Nemani for nerve conduction studies which were performed on July 10, 2012. Dr. Chow's findings on clinical examination [illegible] positive for bilateral ulnar nerve compression and carpal tunnel syndrome. The nerve [illegible]udies were again positive for bilateral ulnar compression but did indicate some [illegible] right side. Dr. Chow saw Petitioner on July 17, 2012, reviewed the nerve [illegible]udies and renewed his surgical recommendation (Petitioner's Exhibits 2 and 4).

On August 15, 2012, Dr. Chow performed surgery on Petitioner's right elbow and the procedure consisted of ulnar nerve decompression and transposition. When Dr. Chow saw Petitioner on August 21, 2012, Petitioner informed him that the numbness/tingling in the right ring and little fingers had resolved. Petitioner was authorized to return to work on August 27, 2012 (Petitioner's Exhibits 2 and 5).

Petitioner was seen again by Dr. Chow on September 23, 2012, and her right elbow condition continued to improve; however, Petitioner was still having right carpal tunnel symptoms. At that time, Dr. Chow recommended right carpal tunnel surgery and, on October 17, 2012, Dr. Chow performed surgery. The procedure consisted of an endoscopic right carpal tunnel release. Dr. Chow saw Petitioner following this surgical procedure and he authorized her return to light duty and full duty work activities on October 24, and November 12, 2012, respectively.

Dr. Sudekum was deposed on August 13, 2012, and his deposition testimony was received into evidence at trial. Dr. Sudekum's testimony was consistent with his medical report and he reaffirmed his opinions regarding causality and that Petitioner's job duties could, in fact, be therapeutically beneficial to her. While Dr. Sudekum acknowledged job duties that accelerate the condition would be an aggravating factor, he did not believe that just because symptoms develop at work that there was necessarily a causal relationship (Respondent's Exhibit 3).

Dr. Chow was deposed on August 28, 2013, and his deposition testimony was received into evidence at trial. Dr. Chow's testimony was consistent with his medical records. In regard to

causality, Dr. Chow testified that Petitioner's job duties were a causative factor for the development of Petitioner's right elbow and hand conditions, both of which ultimately required surgery (Petitioner's Exhibit 8).

Petitioner testified that she was able to return to work in November, 2012; however, she subsequently retired in December, 2012. In regard to her right hand, Petitioner stated that she was no longer experiencing the numbness/tingling sensations and that her hand was pain-free but that her grip strength is less than what was previously. Petitioner is right hand dominant.

Conclusions of Law

In regard to disputed issues (C) and (F) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes that Petitioner sustained a repetitive trauma injury to her upper extremities arising out of and in the course of her employment that manifested itself on February 22, 2011.

In support of this conclusion the Arbitrator notes the following:

Petitioner's testimony regarding the repetitive nature of her job duties was [illegible] Respondent. Respondent's Demands of the Job form (which Petitioner agr[illegible] regard to fine and gross manipulation) is consistent with Petitioner's test[illegible]

The Arbitrator finds the opinion of Petitioner's treating physician, Dr. [illegible] persuasive and credible than that of Respondent's Section 12 examiner, Dr. Sudekum. While Petitioner had other health conditions that may have also been factors in the development of the cubital tunnel and carpal tunnel syndrome conditions, the repetitive work activities that she engaged in were a causative factor.

Petitioner began experiencing symptoms in either 2004 or 2005; however, she did not seek any medical attention nor did she have a diagnosis until she was seen by Dr. Chow and Dr. Nemani on February 22, 2011. This is the date of manifestation.

In regard to disputed issue (E) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes that Petitioner gave notice to Respondent within the time prescribed by the Act.

In support of this conclusion the Arbitrator notes the following:

As aforestated, Petitioner's condition manifested itself on February 22, 2011. Petitioner reported this to Respondent as being a work-related condition on February 23, 2011. This is within the time prescribed by the Act.

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

The Arbitrator concludes that all of the medical treatment provided to Petitioner was reasonable and necessary and that Respondent is liable for payment of the medical bills incurred therewith.

Respondent shall pay reasonable and necessary medical services as identified in Petitioner's Exhibit 9, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule. Respondent shall be given a credit of amounts paid for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

In regard to disputed issue (K) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes that Petitioner is entitled to payment of temporary total disability benefits of one and one-seventh weeks commencing August 16, 2012, through August 26, 2012 (one and four-seventh weeks minus the three day waiting period).

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 15% loss of use of the right arm and 15% loss of use of the right hand.

In support of this conclusion the Arbitrator notes the following:

Petitioner was diagnosed with right cubital tunnel and right carpal tunnel syndrome, both of which required surgery.

Petitioner's complaints of numbness/tingling and pain have resolved; however, she still has complaints of diminished grip strength in her right hand. Petitioner is right hand dominant.

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF ADAMS)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

RANDALL L. WRIGHT,
Petitioner,
vs.
HALVERSON CONSTRUCTION CO,
Respondent,

NO: 11WC 48971

15IWCC0078

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner, herein and notice given to all parties, the Commission, after considering the issues of medical expenses, temporary total disability, permanent 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 30, 2014, is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $17,089.00. 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: JAN 30 2015
MJB/bm
o-1/27/15
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WRIGHT, RANDALL L
Employee/Petitioner

Case# **11WC048971**

HALVERSON CONSTRUCTION CO
Employer/Respondent

15IWCC0078

On 6/30/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% 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:

0834 KANOSKI BRESNEY
CHARLES EDMISTON
129 S CONGRESS
RUSHVILLE, IL 62681

1337 KNELL LAW LLC
MATT BREWER
504 FAYETTE ST
PEORIA, IL 61603

15IWCC0078

STATE OF ILLINOIS)
)SS.
COUNTY OF ADAMS)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

RANDALL L. WRIGHT,
Employee/Petitioner

v.

HALVERSON CONSTRUCTION CO.,
Employer/Respondent

Case # 11 WC 48971

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Maureen Pulia**, Arbitrator of the Commission, in the city of **Quincy**, on **6/4/14**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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 **6/23/11**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

Petitioner's current condition of ill-being as it relates to his lumbar spine *is* causally related to the accident through 10/4/11.

Petitioner's current condition of ill-being as it relates to his bilateral hips *is not* causally related to the accident.

Petitioner's current condition of ill-being as it relates to his right knee *is not* causally related to the accident.

In the year preceding the injury, Petitioner earned **$59,147.40**; the average weekly wage was **$1,137.45**.

On the date of accident, Petitioner was **55** 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 **$7,233.04** for TTD, **$00.00** for TPD, **$00.00** for maintenance, and **$00.00** for other benefits, for a total credit of **$7,233.04**.

Respondent is entitled to a credit of **$00.00** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $758.30/week for 9-2/7 weeks, commencing 8/1/11 through 10/4/11, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $669.64/week for 15 weeks, because the injuries sustained caused the 3% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

Respondent shall pay reasonable and necessary medical services for petitioner's lumbar spine from 6/23/11 through 10/4/11, as provided in Sections 8(a) and 8.2 of the Act. Petitioner's claim for medical services related to his bilateral hips and right knee is denied.

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

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

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

6/25/14
Date

ICArbDec p. 2

JUN 30 2014

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

Petitioner, a 55 year old carpenter, sustained an accidental injury that arose out of and in the course of his employment by respondent on 6/23/11. Petitioner is alleging injuries to his back, bilateral hips and right knees. On 6/23/11 petitioner was a steward on a bridge job. He testified that he was the first one there in the morning and the last to leave at the end of the day. Petitioner first worked for respondent in 1994. He then worked on and off for respondent. Petitioner denied any pain in his low back, hips or trouble walking prior to 6/23/11.

On 6/23/11 the petitioner and the crew were wrecking out underneath the bridge. Petitioner was in a lift over the water. Petitioner testified that the person controlling the lift got him stuck underneath a steel beam. Petitioner testified that the lift was slammed against the bridge and when it broke loose the side rails hit him on both sides of his hips. Immediately after the accident petitioner notified Mr. Gerdes, his supervisor, of the accident. Petitioner testified that Gerdes told him to suck it up and get back to work. Petitioner testified that during lunch he could not sit, and when he tried to bend over he had pain. Petitioner testified that he asked to fill out an accident report and was told they did not have any.

Petitioner testified that the next day he could not walk. He went into work and told Gerdes that he could not work. Petitioner was sent to MOHA.

On 6/24/11 petitioner presented to Midwest Occupational Health Associates. Petitioner was seen by Dr. Gordon and his physician's assistant. Petitioner gave a history of being on a lift on 6/23/11 and the driver got the basket caught on a beam. He reported that the driver jerked it loose from the beam and he got slammed against the handrail of the lift. He complained of pain in the lower back and coccyx area. He also complained of pain in his right knee and some stiffness in his neck, mostly on the left side. Petitioner gave a history of undergoing a fusion in his spine in December 1995 following an unrelated work injury. Petitioner was examined and diagnosed with a lumbar back strain, status post lumbar back surgery in December 1995 with a fusion; right knee pain/strain; and cervical neck pain.

On 6/24/11 petitioner underwent x-rays of the lumbar spine. The impression was moderate degenerative loss of disc height at L4 – L5 with minimal degenerative retrolisthesis.

On 6/27/11 petitioner followed up at Midwest Occupational Health Associates. He stated that his back was doing better, but was still sore. He stated that the medications seemed to be helping a little. He complained of pain in the middle back area and on his right side. On 7/11/11 petitioner stated that his back was getting worse and the medications were not helping. He rated his pain at a 10 out of 10 in his lumbar back area and around into his groin. Petitioner was diagnosed with a lumbar back strain. Dr. Gordon prescribed additional

medications and placed petitioner on restrictions of no lifting over 50 pounds, no pushing or pulling over 50 pounds, no repetitive way spending, and no working overtime. On 7/19/11 petitioner reported that he was getting worse. He stated that his left leg was also hurting. He stated he could not squat or pivot, bend down, or stand up straight. Petitioner stated that he was doing his normal job despite the restrictions that were placed on him. He rated his pain at a 5 on a scale of 10 in his lumbar back area with radiculopathy symptoms down into his left lower extremity. He also complained of some pain into his groin area. Petitioner was diagnosed with a lumbar back strain. An MRI was ordered. Petitioner was given additional pain medications. Petitioner's restrictions were changed to no lifting over 25 pounds, no pushing or pulling over 25 pounds, no repetitive or awkward motions, no kneeling or squatting, no climbing of stairs or ladders, no repetitive waist bending, and no overtime.

On 7/25/11 petitioner underwent an MRI of the lumbar spine. The impression was right lateral disc protrusion at L3 – L4. Bony foraminal compromise at L4 – L5 was noted. There was no evidence of canal stenosis or an acute process. The same day petitioner returned to Midwest Occupational Health Associates. He complained of pain in his lower back. He stated that the pain radiates down his right leg to his toes. He also reported that last week he had pain in his lower back with radiation down into his left foot toes. He stated that the prednisone helped the most. Dr. Gordon reviewed the MRI results. He continued petitioner's work restrictions, and referred him to a spine surgeon. Dr. Gordon was also the opinion that petitioner may benefit from some epidural steroid injections.

Petitioner testified that he continued to work until 8/1/11. He stated that he did not do his regular work and just stood around. He stated that he pulled nails out of wood. He testified that he still had pain in his hips while performing these activities.

On 8/18/11 petitioner underwent a cortisone injection into his left and right hip. This was performed by Dr. Sharma.

On 8/18/11 petitioner was seen by Dr. Payne at Midwest Occupational Health Associates. Petitioner gave a history of being on a lift that got stuck. When it finally broke loose petitioner sustained a big jerk. He stated that the basket struck him in the low back. Since that time petitioner has had low back pain, achy in nature. He also reported pain down the thighs that started out on one side, then jumped to the other side. Dr. Payne was of the opinion that petitioner's pain may be emanating from his hips, as he does have significant degenerative hip disease bilaterally. He stated that he was not convinced that petitioner's symptomatology was emanating from his spine. Dr. Payne consulted with Dr. Gordon after examining petitioner. Dr. Gordon discussed corticosteroid hip injections for diagnostic/investigative purposes. Dr. Gordon believed it was appropriate to determine where

petitioner's pain was emanating from. He was of the opinion that if petitioner has relief, and it appears that his symptoms have been emanating from the hips due to degenerative disease, then this would not be a work-related condition.

On 9/2/11 petitioner followed up with Dr. Gordon after undergoing intra-articular injections of his hips. Petitioner stated that he had relief for about 2 to 3 days. Petitioner complained of pain in his back along with pain in his bilateral hips and down both his extremities to his ankles. Dr. Gordon examined petitioner and his impression was lumbosacral pain, bilateral lower extremity pain/parathesias down to the level of his ankles, and bilateral hip arthritis. Dr. Gordon was of the opinion that petitioner has significant/advanced arthritis of his hips. He reviewed with petitioner the mechanism of the injury and was of the opinion that this would not be expected to cause a pathological progression of his degenerative hip condition and that his arthritis in and of itself is not a work-related or an aggravated condition. Dr. Gordon was of the opinion that petitioner's bilateral leg pain could be related to his hips, but also may be related to his lumbar region. Dr. Gordon recommended some electrodiagnostic studies.

On 9/7/11 petitioner presented to Dr. Narla for an EMG. He gave a history of being hit on the back while he was in a basket of the lift. He reported some pain in the back radiating down to the right more than the left side. The EMG showed very minor degree of positive waves in the lower paraspinal muscles raising the question of posterior branches arising from the nerve root irritation. No evidence of any peroneal motor neuropathy, or any large fiber neuropathy were noted.

On 9/12/11 petitioner followed up with Dr. Gordon after undergoing electrodiagnostic studies of his lower extremities with Dr. Narla. Dr. Narla noted no appreciative changes suggestive of ongoing radiculopathy. He also noted a very minor degree of positive waves of the lower paraspinal muscles. Petitioner complained of pain in his lower back, pain in his hip girdle region bilaterally, along with intermittent pain down his bilateral lower extremities to his knees. Dr. Gordon examined petitioner and his impression was lumbosacral pain, bilateral hip arthritis, and bilateral lower extremity pain/parathesias to the level of his knees. Dr. Gordon was of the opinion that petitioner had arthritic changes of his hips and may need hip replacements. With regard to his back pain Dr. Gordon was of the opinion that petitioner had some radiation of symptoms to the level of his knees at this point. Dr. Gordon ordered a CT myelogram. He stated that if it did not reveal any nerve obstruction than he would recommend a home exercise program for him. With regards to work, he restricted petitioner to no lifting greater than 25 pounds or performing any routine bending at the waist. He restricted petitioner from pushing or pulling over 15 pounds.

On 9/20/11 petitioner presented to Dr. Schopp. Petitioner gave a history of minimal antecedent symptoms before the accident. He stated that the accident dramatically changed his symptoms. Petitioner gave a history of being in a lift in which something obstructed the continued motion of the lift. The lift suddenly gave way and caused petitioner to be violently struck across the back by the handrail inside the basket. He stated that he was hit in the posterior right aspect of his right hip. Petitioner reported debilitative symptoms since then. Petitioner complained of pain in the right hip into the right groin area worse with activity, and worse with standing. He reported difficulty arising or sitting in a chair due to right hip pain. He stated that some of the pain is across his back, but mostly posteriorly in the buttock and deep where the hip would be. He admitted to minor similar symptoms in the contralateral hip. He denied radicular symptoms. Dr. Schopp examined petitioner and reviewed his x-rays of his hips. He was of the opinion that since petitioner had failed conservative treatment a treatment algorithm for his hip arthritis should be discussed. Petitioner stated that he was motivated to proceed with a total hip arthroplasty, but Dr. Schopp indicated that this was a suboptimal solution. However due to petitioner's severe symptoms, he stated that he was motivated to proceed. Dr. Schopp recommended an right arthroplasty.

On 9/28/11 petitioner underwent a lumbar spine myelogram and CT scan of the lumbar spine post-myelogram because of lumbar back strain with bilateral lower extremity pain. The impression of the myelogram was subtle extradural defect along the right lateral aspect of the L4 – L5 disc space level. The results of the CT of the lumbar spine post-myelogram was narrowing and degenerative change in abnormality at the L4 – L5 disc space level. Spur formation about the ventral aspect of the right lamina at L4 and some asymmetric hypertrophy of the ligamentum flavum on the right side at the L4 level was noted as well. Also noted was some calcification of the ligamentum flavum likely representing myositis ossificans focally. It was thought that this may be due to chronic irritation from the spur formation about the right lamina.

On 10/4/11 petitioner followed up with Dr. Gordon. Dr. Gordon reviewed the results of the CT myelogram. Petitioner complained of pain of his axial lower back region and also medial hip regions bilaterally. He no longer had any complaints of pain down his legs bilaterally. Petitioner underwent x-rays of his hips which revealed severe degenerative changes of his hips. Petitioner told Dr. Gordon that he did indeed have pain in his hips in the past but did not recall it being as severe as it is now. Dr. Gordon examined petitioner and diagnosed history of lumbosacral strain. He noted that petitioner had notable degenerative changes of his lumbar region following a lumbar fusion in 1995. He stated that petitioner was evaluated by a spine surgeon and spine surgery was not being recommended. With regard to petitioner's lumbar pain Dr. Gordon was of the opinion that petitioner was at maximum medical improvement. Petitioner was also

diagnosed with bilateral hip arthritis that was severe bilaterally. Dr. Gordon noted that when he originally evaluated petitioner his main complaint was pain of his lower back with pain down each of his legs, more of a radicular pattern. Based upon his mechanism of injury Dr. Gordon did not expect petitioner to have a pathological aggravation of his hips as a result of the incident. He also noted that petitioner's hip x-rays did not reveal any acute findings and that his hips showed long-standing evidence of arthritis. Petitioner did not agree with this assessment and was of the opinion that his hip conditions should be work-related. Dr. Gordon discussed with him that he had originally reported that he had had hip pain in the past, and the natural progression/course of arthritis, especially at this stage, would be for him to need hip replacements whether the work incident happened or not. Dr. Gordon discharged petitioner from his care.

Petitioner was paid temporary total disability through 10/4/11. Thereafter he did not receive any disability payments.

On 10/27/11 petitioner underwent a total right hip arthroplasty. His postoperative diagnosis was right hip osteoarthritis. This procedure was performed by Dr. Schopp. Petitioner followed up postoperatively with Dr. Schopp.

On 12/20/11 Dr. Joseph Williams performed a Section 12 examination of petitioner at the request of the respondent. Dr. Williams took a detailed history, and performed a physical examination and a record review. Petitioner gave a history that he was in a snorkel basket on 6/23/11 when the operator got it caught between two objects. When it broke away it hit him in the low back. He stated that it happened at approximately 11 AM. Petitioner continued working that day. He stated that he then went to work the next day and told them that he was having too much pain, and could not work. Petitioner provided a history of his lumbar fusion in 1995. Petitioner denied any past medical history for any problems with his bilateral hips. He denied seeing anyone or ever being treated for pain in his bilateral hips. Petitioner continued to have subjective complaints in both hips. Dr. Williams was of the opinion that petitioner's subjective complaints were totally out of proportion to what one would expect after a right total hip replacement. Dr. Williams' diagnosis was that petitioner had osteoarthritis of both hips, right greater than the left, obviously of long-standing duration. He opined that it had nothing to do with trauma or with his work related injury. He was of the opinion that it takes many years for the radiological changes to occur in the hips. He had no joint space. Petitioner had sclerosis of the bone. He had a subchondral cyst, and the femoral head was no longer around. Dr. Williams opined that petitioner's osteoarthritis of both of his hips has nothing to do with the alleged injury on 6/23/11. Dr. Williams prognosis of petitioner was excellent after the right total hip replacement surgery. He did not believe petitioner needed any further treatment relative to his alleged injury on 6/23/11. Dr. Williams was of the opinion that petitioner was

able to work without restrictions, as he did for several weeks after the alleged injury on 6/23/11 before seeing a physician. Dr. Williams opined that petitioner's osteoarthritis was due to hereditary, wear and tear, his obesity, and was idiopathic in nature. Dr. Williams opined that with respect to the injury petitioner sustained on 6/23/11 he was at maximum medical improvement within a matter of days as he was able to continue working until he saw physician.

On 2/17/12 Dr. Schopp drafted a letter to petitioner's attorneys. His stated that his diagnosis for petitioner was hip arthritis. He opined that this condition was exacerbated by the events in June, as described by petitioner.

On 4/6/12 petitioner followed up with Dr. Schopp. Petitioner attributed his mild degenerative changes and a meniscal tear of the lateral meniscus in his right knee to the rotation of his knee during the right hip surgery. Petitioner stated that he had no antecedent symptoms before his right hip replacement.

On 4/12/12 petitioner underwent an arthroscopy of the right knee. His postoperative diagnosis was chondral injury, right medial femoral condyle. This procedure was performed by Dr. Schopp. Petitioner followed up postoperatively with Dr. Schopp.

On 5/24/12 petitioner underwent a left total hip arthroplasty. His postoperative diagnosis was left hip osteoarthritis. This procedure was performed by Dr. Schopp. Petitioner followed up postoperatively with Dr. Schopp.

On 6/11/12 the evidence deposition of Dr. Schopp, an orthopedic surgeon, was taken on behalf of petitioner. Dr. Schopp opined that although petitioner stated that he had mild symptoms prior to the injury in June 2011, that his symptoms were dramatically worse after the injury. Dr. Schopp opined that the injury dramatically worsened petitioner's symptoms in his hips, and caused the need for the left and right arthroplasty. Dr. Schopp opined that in people requiring hip replacements their symptoms can be described as back pain and groin pain. He also was of the opinion that doctors can sometimes misdiagnose a hip injury as a back injury.

On cross-examination Dr. Schopp stated that his opinions are in part related on the accuracy of the history provided him by the petitioner. Dr. Schopp opined that petitioner's left and right hip arthritis predated the injury on 6/23/11. Dr. Schopp opined that petitioner provided a history wherein he stated that he had complaints to his right and left hip predating the injury on 6/23/11. Dr. Schopp stated that he was not aware that petitioner did not provide a history to Dr. Gordon regarding any right or left complaints immediately following the accident, or that the history petitioner provided him was different from the history he provided other healthcare providers. Dr. Schopp stated that if the actual history of the incident varies from what petitioner told him his opinions

could also change. Dr. Schopp stated that if it could be shown that petitioner did not strike his left hip during the accident, and there was no evidence of acute trauma on the diagnostic tests done to both the right and left hip, that his opinions as to causation as it relates to an aggravation in this case could change. Dr. Schopp opined that it is more likely than not that the accident on 6/23/11 did not cause an injury to petitioner's right knee, since petitioner's first complaints of right knee pain did not occur until after his right knee arthroplasty. He further opined that the condition petitioner suffered from in his right knee may not be related to the surgical procedure that he did on the right hip, and that the condition petitioner had with respect to his left and right hips may also not be related to the accident on 6/23/11. Dr. Schopp opined that prior to the accident on 6/23/11 petitioner had arthritis in both hips that was advanced, and the diagnostic tests taken after the accident showed no acute findings.

On 8/8/12 the evidence deposition of Dr. Williams was taken on behalf of the respondent. Dr. Williams was of the opinion that in order to aggravate his arthritis in his hip that he would need a direct trauma to the hip, and petitioner did not experience any direct trauma to his hips on 6/23/11.

On 9/28/12 petitioner was released from care. He stated that since being released from care he does not feel like the same person. He reported pain when it rains, and difficulty sleeping on his hips. Petitioner reports pain when bending a certain way. He reported some popping about three times a week. Petitioner testified that he never went back to work as a carpenter. Petitioner's currently on Social Security Disability.

On 6/25/13 petitioner underwent another Section 12 examination performed by Dr. Williams at the request of the respondent to evaluate petitioner's bilateral hips and bilateral knee pain. Petitioner stated that he could not squat, pivot, walk, go up and down hills, lift, work in mud, or balance. He stated that it was hard for him to climb, walk long distances, push kids on the merry-go-round, get in and out of his car truck, and carry groceries. Following an examination and record review, Dr. Williams diagnosed a lumbar strain, status post lumbar back surgery in December 1995 as a result of the incident he sustained on 6/23/11. Dr. Williams opined that this strain had resolved. He opined that petitioner's condition with regards to his hips is not causally related to the injury on 6/23/11. He also noted that petitioner had significant symptom magnification which did not correlate with his physical examinations. He was of the opinion that there is no objective medical evidence to support petitioner's subjective complaints. Dr. Williams opined that petitioner did not need any further treatment and was able to work without restrictions with regard to his lumbar strain.

The respondent offered into evidence video surveillance of petitioner on 5/11/13, 5/12/13, 7/6/13, 7/20/13, and 7/27/13. On 5/11/13 petitioner was observed loading shovels, a level, and several pieces of rebar into his car. Petitioner was also seen at a car accident scene. Petitioner was seen lifting a BBQ grill into the bed of his

truck with another individual. Petitioner was seen carrying several landscaping bricks, placing them on the ground, digging out a tree root, shoveling dirt and conversing with several individuals. Petitioner was seen bending at the waist, swinging a pick axe, and using a shovel many times. On 5/12/13 petitioner was observed changing a tire on his trailer while utilizing a jack stand and an air compressor. He was also observed cutting down several trees, carrying tree branches, and using a chainsaw and handsaw. While performing these activities petitioner was observed bending and kneeling on multiple occasions. The surveillance taken 7/6/13, 7/20/13, and 7/27/13 did not show petitioner doing any significant activities.

Petitioner testified that since being released from care by Dr. Schopp the only sport he performs is fishing. He stated that he does some yard work, and uses hand and power tools. He stated that he can shovel a little bit, and can lift and carry, and push and pull a little if not too heavy. He stated that he can cut his grass with a riding lawnmower, trim hedges with an electric hedge trimmer, throw grass seed down, and has no problem operating a lawnmower.

F. IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY?

Petitioner is alleging that his current condition of ill-being as it relates to his bilateral hips and low back is causally related to the injury he sustained on 6/23/11. On that date petitioner was in a lift bucket and was slammed against the rails when it broke loose after being stuck. When petitioner first sought treatment for his injuries the next day he complained of pain in his lower back and coccyx area, right knee and stiffness in his neck, mostly on the left side. Petitioner made no mention of any hip complaints. Petitioner was diagnosed with a lumbar strain, right knee strain and cervical neck pain.

On 6/27/11 petitioner reported that his back pain was improved, although it was still sore. He complained of pain in the middle back area and on his right side. He stated that his back pain was getting worse. Petitioner again made no mention that he struck his hips on the rails of the bucket or that he had any hip pain. On 7/25/11 petitioner continued to complain of low back pain radiating to his left toes. Again, no mention was made of any hip problems.

On 8/18/11 petitioner presented to Dr. Payne. He again stated that he sustained a big jerk while in the lift and struck his low back on the basket. No mention was made of striking his hips on the basket. Dr. Payne was of the opinion that petitioner's pain may be emanating from his hips, since he had significant degenerative hip disease bilaterally. He injected petitioner's hips. Dr. Gordon was of the opinion that if petitioner had relief from the injections, that his symptoms may be emanating from his hip due to his degenerative disease. Petitioner did not report any lasting relief from the injections. He only had relief for a few days. He continued to complain of back pain. Dr. Gordon opined on 9/2/11 that the mechanism of the injury would not be expected to cause a

pathological progression of his degenerative hip condition and that petitioner's hip arthritis in and of itself is not a work related or an aggravated condition.

Even when petitioner presented to Dr. Narla on 9/7/11 for an EMG he again gave a history of being hit in the back while he was in a lift basket. He made no mention that he struck his hips. Petitioner continued with complaints of hip and low back pain that radiates down his legs intermittently. On 9/12/11 Dr. Gordon was of the opinion that petitioner would need bilateral hip replacements.

Following this recommendation for bilateral hip replacements petitioner presented to Dr. Schopp. He reported minimal bilateral hip complaints prior to the accident on 6/23/11 that were now dramatically worse. For the first time petitioner gave a different accident history. He stated that when the lift broke loose he was violently struck against across the back by the handrail inside the basket and was hit in the posterior right aspect of the right hip. The arbitrator notes that until this point petitioner had never mentioned that he struck his right hip while in the basket. Based on this history Dr. Schopp opined that petitioner's bilateral hip problems and his need for bilateral hip arthroplasty are casually related to the accident on 6/23/11.

By 10/4/11 petitioner's radiculopathy has resolved. His diagnostic tests revealed very severe degeneration of the hips and bone on bone. Dr. Gordon assessed that petitioner sustained a lumbar strain as a result of the injury and did not need any spinal surgery. He opined that with respect to his lumbar spine petitioner had reached maximum medical improvement. Dr. Gordon opined that not only did the mechanism of injury not support an injury to his bilateral hips, but the diagnostic tests of his bilateral hips did not show any acute findings. Dr. Gordon opined that petitioner had hip pain in the past, and the natural progression of arthritis, especially at the stage petitioner is at, would necessitate the need for hip replacements.

Petitioner gave Dr. Williams a history of being hit in his low back by the lift when it broke loose. Petitioner also denied any past medical history of problems with his bilateral hips. The arbitrator notes that this history directly contradicts the history he provided Dr. Gordon and Dr. Schopp, wherein he stated that he had prior problems with his bilateral hip before the accident on 6/23/11. Dr. Williams also noted that petitioner's hips were bone on bone. He opined that petitioner had osteoarthritis of his hips that was obviously longstanding. He also opined that petitioner's subjective complaints were totally out of proportion to what one would expect after a total right hip replacement. Dr. Williams opined that petitioner's osteoarthritis of both hips has nothing to do with his injury on 6/23/11. Dr. Williams opined that absent any acute findings on the diagnostic test of the right and left hips, and the fact that petitioner had advanced arthritis in both hips prior to 6/23/11, there is no causal connection between petitioner's current condition of ill-being as it relates to his bilateral hips and the accident on 6/23/11.

When Dr. Schopp was deposed he stated that if the actual accident history was different from what petitioner provided him, his causal connection opinions regarding petitioner's bilateral hips could be different. He opined that if it can be shown that petitioner did not strike his left hip during the accident, combined with the fact that there is no evidence of an acute trauma on the diagnostic tests taken of the left and right hip, his causal connection opinion would change. He further opined that petitioner's current condition of ill-being as it relates to his right knee is not causally related to the accident on 6/23/11 because petitioner readily admitted that he did not have any real problems with his right until after the right hip arthroplasty on 10/27/11.

In addition to the doctor's opinions, the arbitrator has significant questions regarding the petitioner's credibility. First, the arbitrator notes that petitioner gave no history that he struck his hips in the bucket until after the bilateral hip replacements were recommended nearly 4 months after the accident. Additionally, the petitioner reported that he could not squat, pivot, bend down or stand up straight, but video surveillance of him taken on 5/11/13 and 5/12/13 showed petitioner loading shovels, a level, and several pieces of rebar into his car. Petitioner was also seen at a car accident scene, seen lifting a BBQ grill into the bed of his truck with another individual, seen carrying several landscaping bricks and placing them on the ground, digging out a tree root, shoveling dirt, and conversing with several individuals. Petitioner was also seen bending at the waist, swinging a pick axe, and using a shovel many times. He was observed changing a tire on his trailer while utilizing a jack stand and an air compressor, cutting down several trees, carrying tree branches, and using a chainsaw and handsaw. While performing these activities petitioner was seen bending and kneeling on multiple occasions.

Based on the above, the arbitrator finds the petitioner has failed to prove his current condition of ill-being as it relates to his bilateral hips and right knee is causally connected to the injury he sustained on 6/23/11. The arbitrator further finds the petitioner sustained a lumbar strain that resolved by 10/4/11. The arbitrator bases this opinion on the fact that there is no credible evidence to support a finding that petitioner's bilateral hips were struck as a result of the injury he sustained on 6/23/11; the opinions of Dr. Gordon, Dr. Williams and Dr. Schopp that petitioner had severe osteoarthritis and "bone on bone" in his hips before the injury and there were no acute trauma findings on the diagnostic tests of his hips, and that the mechanism of injury was not consistent with his compliants; and that petitioner's subjective complaints were out of proportion to his objective findings, and what he was seen doing on the video surveillance. The arbitrator also finds it significant that petitioner did not add "striking his hips while in the lift" to his accident history until after he found out he needed bilateral hip arthroplasty and wanted it covered by workers' compensation.

J. WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY? HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES?

Having found the petitioner only sustained a lumbar strain as a result of the injury he sustained on 6/23/11, and was found to be at maximum medical improvement with respect to this injury by 10/4/11, the arbitrator finds the respondent shall pay the reasonable and necessary medical expense associated with the treatment of his lumbar spine from 6/23/11 through 10/4/11 pursuant to Section 8(a) and 8.2 of the Act. The arbitrator denies petitioner's claim for treatment to his right knee and bilateral hips finding they are not causally related to the injury petitioner sustained on 6/23/11.

Respondent shall be given a credit of 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.

K. WHAT TEMPORARY BENEFITS ARE IN DISPUTE?

Petitioner is alleging he is entitled to temporary total disability benefits from 8/1/11 through 9/28/12. The respondent alleges the petitioner is only entitled to temporary total disability benefits from 8/1/11 through 10/4/11. Having only found the petitioner's lumbar spine condition causally related to the injury on 6/23/11, and that petitioner has reached maximum medical improvement with respect to this condition by his treater, Dr. Gordon on 10/4/11, the arbitrator finds the petitioner is entitled to temporary total disability benefits from 8/1/11 through 10/4/11, a period of 9-2/7 weeks.

L. WHAT IS THE NATURE AND EXTENT OF THE INJURY?

Having found the only condition causally related to the injury on 6/23/11 is petitioner's lumbar spine, and Dr. Gordon and Dr. Williams opined that as a result of this injury petitioner only sustained a lumbar strain, and was capable or working full duty without restrictions with respect to this injury on 10/4/11, the arbitrator finds the petitioner sustained a 3% loss of use of his person as a whole pursuant to Section 8(d)2 of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
SANGAMON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

RYAN HOMER,
Petitioner,
vs.
MAHKOVTZ HEATING & COOLING,
Respondent,

NO: 12WC 27288

15IWCC0079

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 21, 2014, is hereby affirmed and adopted.

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

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

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: JAN 3 0 2015
MJB/bm
o-1/27/15
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

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

HOMER, RYAN
Employee/Petitioner

Case# **12WC027288**

MAHKOVTZ HEATING & COOLING
Employer/Respondent

15IWCC0079

On 3/21/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

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EAST ALTON, IL 62024

LAW OFFICE OF PAUL O WATKISS
KEVIN DOYLE
1804 N NAPER BLVD SUITE 380
NAPERVILLE, IL 60563

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)

Ryan Homer
Employee/Petitioner

v.

Mahkovtz Heating & Cooling
Employer/Respondent

Case # 12 WC 27288

Consolidated cases: _____

15IWCC0079

An *Application for Adjustment 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 **Springfield**, on **February 21, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **February 7, 2012**, Respondent *was* operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship *did* exist between Petitioner and Respondent.

On this date, Petitioner *did* sustain an accident that arose out of and in the course of employment.

Timely notice of this accident *was* given to Respondent.

Petitioner's current condition of ill-being *is* causally related to the accident.

In the year preceding the injury, Petitioner earned **$20,467.72**; the average weekly wage was **$444.95**.

On the date of accident, Petitioner was **36** 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 **$31,442.78** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$31,442.78**.

Respondent is entitled to a credit of $0 under Section 8(j) of the Act.

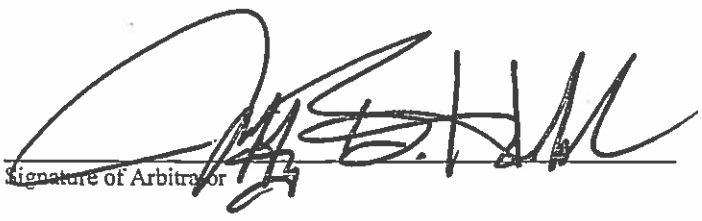
ORDER

Respondent shall provide and pay for all prospective medical treatment recommended by Dr. Gornet regarding the proposed anterior fusion at L5-S1 and disc replacements at L4-L5 and L3-L4 as described in his deposition in this case, pursuant to Sections 8(a) and 8.2 of the Act. Respondent shall authorize the said treatment in order to facilitate this award of prospective medical treatment.

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 20, 2014
Date

ICArbDec19(b)

MAR 21 2014

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

The Parties agree that on February 7, 2012, the Petitioner and the Respondent were operating under the Illinois Worker's Compensation Act and that their relationship was one of employee and employer. On that date the Petitioner sustained an accidental injury that arose out of and in the course of the employment. They further agree that the Petitioner gave the Respondent notice of the accident within the time limits stated in the Act and that the Petitioner's current condition of ill-being is causally connected to the accidental injury sustained. All TTD and medical bills have been paid.

At issue in this hearing is as follows: (1) Prospective Medical Treatment

STATEMENT OF FACTS

The Petitioner injured his low back on February 7, 2012 when he bent over and tried to pick up a PVC vent pipe while installing a furnace.

The first medical treatment was at the emergency room, where he was examined and advised to follow up with his primary care physician. Petitioner followed up with his PCP, Dr. Laws. (Pet Ex 5) Dr Laws referred Petitioner to Dr. Van Fleet. Petitioner treated with Dr. Van Fleet from April 6, 2012 through June 8, 2012. Dr. Van Fleet ordered physical therapy and an MRI. Later, injections to the lumbar spine were ordered. (Pet Ex 3)

Therapy took place at Carlinville Area Hospital and Petitioner did not show improvement. (Pet Ex 1) The Lumbar MRI was performed on May 22, 2012 and showed diffuse pathology at the L3-4, L4-5 and L5-S1 levels. (Pet Ex 2) Dr. Van Fleet's impression on the last visit was: disc disease and radiculopathy. (Pet Ex 3) A lumbar ESI procedure was done on July 12, 2012. (Pet Ex 4)

Petitioner testified that he was not satisfied with Dr. Van Fleet, so he sought treatment by Dr. Eavenson, who referred him to Dr. Gornet. Dr. Eavenson had ordered a CT/Myelogram of the lumbar spine, which was performed on July 30, 2012. The radiologist found significant lumbar pathology, including severe disc height loss with vacuum phenomenon at L5-S1 with left greater than right moderate to severe foraminal encroachment and posterior broad based disc/osteophyte complex and endplate sclerosis, along with posterior mild broad based bulging at the L3-4 and L4-5 levels.(Pet Ex 2)

Petitioner was first seen by Dr. Gornet on August 23, 2012. Dr. Gornet recommended that Petitioner be weaned off narcotic medication and ordered a repeat Lumbar MRI. A discogram was to be considered to try to isolate the symptomatic levels in the lumbar spine. Follow up was October 18, 2012. Dr. Gornet thought that the MRI showed annular tear and disc herniation at both L3-4 and L4-5, with the structural problem that was previously noted at L5-S1. As of October 24, 2012, Dr. Gornet thought that the correct treatment plan would be a L4-5 posterior fusion with hardware. (Pet Ex 6)

Petitioner underwent a CT/Discogram by Dr. Gornet on November 20, 2012. (Pet Ex 2) The study was said to be non-provacative at L2-3 and L3-4. A provocative response with concordant pain was noted at L4-5. (Pet Ex 7)

Petitioner was seen in follow-up by Dr. Gornet on December 3, 2012, February 4, 2013, June 20, 2013 and October 21, 2013. (Pet Ex 6)

Dr. Gornet has offered Petitioner two options of surgery. The first option is a three level lumbar fusion from L3 to S1. The second option is fusion anteriorly of L5-S1, with disc replacement at L4-5 and L3-4. (Pet Ex 8).

Respondent disputes the need for the proposed surgeries.

Respondent obtained a UR review from Alaris and Dr. Borkowski "Independent Occupational Medicine Specialist" on December 26, 2012. The proposed fusion at L4-5 with disc replacement at L3-4 and L4-5 was found non-certified. (Res Ex 1)

Petitioner has been kept off work since February 8, 2012, per the medical records and the stipulation of the Parties at trial. (Pet Ex 3, 5 and 6) All TTD has been paid. Petitioner's current restrictions of light duty work, with a 10 pound lifting limit and no repetitive bending keep him from returning to work at Respondent.

Petitioner testified that he wishes to undergo the fusion/disc replacement procedure that has been offered by Dr. Gornet.

Dr Gornet testified via evidence deposition and found a causal connection between the accidental injuries as described by Petitioner and the need for surgery. Dr. Gornet thought that the best option for Petitioner, given his age and desire to go back to work was the fusion/disc replacement surgery. (Pet Ex 8)

The Parties stipulated to causal connection.

CONCLUSIONS OF LAW

K. Is Petitioner entitled to prospective medical care ?

The Arbitrator finds Petitioner to be credible and believes his desire to have the recommended surgery to be genuine. The Arbitrator finds Dr. Gornet's testimony to be credible.

Section 8.7 of the Act requires the Commission to consider utilization review evidence. The Arbitrator does not find the report of Dr. Borkowski to be persuasive. He does not identify the "guidelines" that he relies upon. The U.R. evaluation should be based on standards of care of nationally recognized peer review guidelines as well as nationally recognized treatment guidelines and evidence-based medicine. While the fact that Dr. Borkowski is not a spinal surgeon does not prevent him from rendering U.R. opinions, his stating that "...performing a surgical fusion in addition to disc replacement is not covered by and likely not found acceptable by treatment guidelines" fails to persuade the Arbitrator. Assuming that the objective guidelines set forth in Section 8.7 were considered, a procedure should be considered acceptable or not acceptable.

The Arbitrator finds that the proposed fusion and disc replacement procedure offers Petitioner the best chance of a speedy recovery and for the return to a productive position in the labor force. It is reasonable to conclude that Petitioner's pain and disability will continue without surgery. The proposed surgery is found to be necessary and reasonably required to cure or relieve the effects of the injuries in this case.

Dr. Gornet testified that a repeat work-up would be necessary before performing the surgery. That work up, along with the fusion/disc replacement procedure described by Dr. Gornet in his deposition and requested by Petitioner is hereby ordered.

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

Ralph Pepper,
Petitioner,
vs.
Metropolitan Trucking Co.,
Respondent,

NO: 10 WC 21081
15IWCC0080

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of temporary 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 February 11, 2014 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $11,600.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JAN 30 2015

MB/mam
o:12/11/14
43

Mario Basurto

David L. Gore

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

PEPPER, RALPH
Employee/Petitioner

Case# **10WC021081**

15IWCC0080

METROPOLITAN TRUCKING CO
Employer/Respondent

On 2/11/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.11% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

4681 MARTAY LAW OFFICE
STEPHEN R MARTAY
134 N LASALLE ST 9TH FL
CHICAGO, IL 60602

1120 BRADY CONNOLLY & MASUDA PC
MATT P SHERIFF
ONE N LASALLE ST SUITE 1000
CHICAGO, IL 60602

15IWCC0080

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

Ralph Pepper
Employee/Petitioner

v.

Metropolitan Trucking Co.
Employer/Respondent

Case # 10 WC 21081

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Arbitrator Andros**, Arbitrator of the Commission, in the city of **New Lenox**, on **October 9, 2013 and in the city of Geneva on December 9, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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 19, 2010**, Respondent ***was*** operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

On this date, Petitioner ***did*** sustain an accident that arose out of and in the course of employment.

Timely notice of this accident ***was*** given to Respondent.

Petitioner's current condition of ill-being ***is*** causally related to the accident.

In the year preceding the injury, Petitioner earned **$28,454.92**; the average weekly wage was **$547.21**.

On the date of accident, Petitioner was **59** years of age, ***married*** with **0** dependent children.

Petitioner ***has*** received all reasonable and necessary medical services.

Respondent ***has*** paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of **$38,870.00** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$0.00** for other benefits, for a total credit of **$38,870.00**.

Respondent is entitled to a credit of **$0.00** under Section 8(j) of the Act.

ORDER

K.
The Arbitrator finds Petitioner has proven by a preponderance of the evidence that he is entitled to temporary total disability benefits and temporary partial disability benefits for time he was off work and the time he worked part time. Petitioner is entitled to temporary total disability benefits at the rate of $364.81 from May 20, 2010 through October 24, 2011, August 2, 2012 through November 4, 2012 and May 20, 2013 through September 19, 2013. Those time periods equate to 105 and 3/7th weeks totaling $38,461.55.

Petitioner is entitled to temporary partial disability of $167.41 per week from October 25, 2011 through August 1, 2012 which equates to 40 and 1/7th weeks totaling $6,720.34. He is further entitled to temporary partial disability of $184.81 per week from November 5, 2012 through May 19, 2013 which equates to 27 and 6/7th weeks totaling $5,148.25.

Respondent is due a credit of $38,870.00 meaning Petitioner is entitled to benefits of $11,460.14.

L.
Having found Petitioner would be able to earn $62,500.00 per year or $1,200.00 per week in the full performance of his duties in the occupation in which he was engaged at the time of the accident per section 8(d)1, and having found he is now earning $360.00 in some suitable employment after the accident, he is entitled to a weekly wage loss differential in the amount of $560.00 per Section 8(d)1 of the Act.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of Arbitrator

Feb 7th, 2014
Date

FEB 11 2014

FINDINGS OF FACT 10 WC 21081

Petitioner testified he was employed by Respondent as a long haul over the road truck driver (Tr. 6-7). His job duties included picking up and delivering general commodity freight (Tr. 7). $547.21 per week is his section 10 wage. He had been employed full time by Respondent for approximately one year (Tr. 6), but he had worked as an over the road truck driver for approximately 35 years (Tr. 7). Over his many years in the business, he picked up special certifications for tankers and hazardous materials as well as being certified as a commercial driver's license instructor (*id.*). He was based out of Springfield, Massachusetts for his entire career and did much cross country driving (Tr. 8).

Accident is not in dispute given his hurt his back operating the grab handle to drop a trailer. After initial care in Bolingbrook and a 22 hour company sponsored train ride home he presented to Dr. Jesse Eisler at the Connecticut Back Center for an examination (Tr. 15-16). Dr. Eisler recommended Petitioner attend some chiropractic sessions at the Enfield Health and Wellness Center (Tr. 16). Petitioner attended six sessions of chiropractic care before returning to see Dr. Daniel Sheehan, Dr. Eisler's partner. On 7/6/10 Eisler recommended he remain off work and get some injections for his back (Tr. 17). . An MRI was done on August 6, 2010 at the Tolland Imaging Center. Dr. Eisler performed medial branch blocks for Petitioner at L4-5 and L5-S1 on the right side on October 12, 2010 (Tr. 17-18). Dr. Eisler on November 11, 2010 and was advised to take some pain medications (Tr. 18). He underwent the lumbar transforaminal epidural steroid injections at L4-5 and L5-S1 on the right side on February 1, 2011 (*id.*). Petitioner saw Dr. Eisler for a final time on March 2, 2011 and he was discharged from care at maximum medical improvement with permanent work restrictions of no truck driving, no lifting over 30 lbs., no standing over 1-2 hours, no walking over 1-2 hours, no sitting over 2-4 hours, no bending or squatting over 1-2 hours and no climbing (Tr. 18-19).

At the request of Respondent, Petitioner presented to Dr. Gerald Becker at Orthopedic Associates of Hartford performed a section 12 exam for Respondent June 6, 2011. Dr. Becker opined Petitioner's injuries were work-related and that the permanent restrictions given to Petitioner by Dr. Eisler were in line with his opinions (Rx 1).

Petitioner testified he continues to suffer from low back pain on the right side which radiates down his right leg The numbness causes him to have issues feeling the pedal of a car. He uses hot packs and takes prescribed Tramadol 20mg. Lastly, he testified that but for his work-injury, he would still be working as a truck driver today and making approximately $70,000.00 to $80.000.00 per year (Tr. 35-36).

Regarding issue (K), what temporary benefits are in dispute, the Arbitrator finds the following:

Had Petitioner been off work from May 20, 2010 through October 9, 2013 and paid his full TTD benefits, he would have been paid $64,519.20. During that time, Petitioner did in fact work two part time jobs. The first job he worked was as a classroom instructor at The New England Tractor Trailer Training School (Tr. 24). He worked that job from October 24, 2011 through August 1, 2012 which is 40 and 2/7th weeks (Tr. 24-25). He was released from that job because he was asked to perform field work which went beyond his permanent restrictions. He was making $296.10 per week meaning he was paid approximately $11,928.68 at that job.

After searching for work for a few months, he found a job as a limousine driver which was within his permanent restrictions. He started that job on November 4, 2012 and worked until May 20, 2013 because there was an issue with his endorsement license to carry passengers (Tr. 28-29). He worked that job for 24 weeks and made approximately $6,480.00 (Tr. 28).

Petitioner was then re-hired by The New England Tractor Training School on September 15, 2013 making $360.00 per week (Tr. 31-32). At the time of hearing he had been working that job for 3 and 4/7th weeks meaning he made approximately $1,285.56. There is no dispute that Petitioner is entitled to the temporary total disability benefits and temporary partial benefits.

The Arbitrator finds as a matter of fact and law Petitioner has proven by a preponderance of the evidence that he is entitled to temporary total disability benefits and temporary partial disability benefits for time he was off work and the time he worked part time. Petitioner is entitled to temporary total disability benefits at the rate of $364.81 from May 20, 2010 through October 24, 2011, August 2, 2012 through November 4, 2012 and May 20, 2013 through September 19, 2013. Those time periods equate to 105 and 3/7th weeks totaling $38,461.55.

Petitioner is entitled to temporary partial disability of $167.41 per week from October 25, 2011 through August 1, 2012 which equates to 40 and 1/7th weeks totaling $6,720.34. He is further entitled to temporary partial disability of $184.81 per week from November 5, 2012 through May 19, 2013 which equates to 27 and 6/7th weeks totaling $5,148.25. Respondent is due a credit of $38,870.00 meaning Petitioner is entitled to benefits of $11,460.14.

Regarding issue (L), what is the nature and extent of the injury, the Arbitrator finds the following:

Section 8(d)1 of the Act states, " If, after the accidental injury has been sustained, the employee as a result thereof becomes partially incapacitated from pursuing his usual and customary line of employment, he shall...receive compensation for the duration of his disability...equal to 66-2/3% of the difference between the average amount which he would be able to earn in the full performance of his duties in the occupation in which he was engaged at the time of the accident and the average amount which he is earning or is able to earn in some suitable employment or business after the accident." The Arbitrator finds his current employment is deemed suitable given his testimony plus the testimony of two CRC's and one other person.

There is no dispute Petitioner can no longer perform his duties as a long haul over the road truck driver.

The key to this case and most wage differential cases is the critical language in the Act section 8(d) 1, in pertinent part, ...the average amount which he would be earning in the full performance of his duties in the occupation which he was engaged at the time of his accident. (Emphasis added). This is informally known as the top number in calculation of the wage differential as cited in the statute.

In the case at bar, this over the road commercial truck driver in the full performance of his duties drove across the country while carrying a CDL A drivers license with official endorsements for hazardous materials plus capability of driving a tanker truck with hazardous materials. His home base was near his residence, up in New England, not in the metro Chicago area or Midwest.

The evidence consists of testimony from the Petitioner, two highly credentialed certified rehabilitation counselors plus a person who does job searches for one of the CRC's.

Petitioner testified he believed he would be making approximately $70,000.00 to $80,000.00 per year if he was still working full time as a long haul over the road truck driver (Tr. 36). He testified that is what his friends in the industry are making today (Tr. 12).

Petitioner offered the testimony of Mr. Courtney Olds, a vocational rehabilitation counselor who works in Massachusetts and is very familiar with the area where the Petitioner lives plus the job market in that region. Mr. Olds testified he was contacted by Petitioner's attorney in July of 2012 to provide a report establishing what Petitioner would be making as an over the road truck driver (Px 1 at 6 Mr. Olds testified Petitioner was an experienced over the road truck driver with a hazmat license meaning he could haul loads with dangerous chemicals (Px 1 at 8-9). He testified that he conducted a labor market survey in the greater Springfield, Massachusetts area, where Petitioner actually lived, focusing on the job market for someone with Petitioner's background and experience of 36 years as an over the road truck driver (Px 1 at 9-10). He contacted companies for this survey at the end of July 2012 (Px 1 at 10) and specifically asked what someone with 36 years experience as an over the road truck driver would earn at each company (Px 1 at 10-11).

A & R Transportation in Springfield, Massachusetts was the first company Mr. Olds contacted and he spoke with a woman named Casey who he believed was a recruiter (Px 1 at 12). Casey indicated the average salary was $65,000.00 per year. Mr. Olds testified that salary was in line with what he would expect for someone with Petitioner's work background (Px 1 at 12-13).

The next company Mr. Olds contacted was Barr Nunn Transportation located in Granger, Iowa (Px 1 at 13). He indicated Barr Nunn had drivers located in Springfield, Massachusetts (*id.*). He spoke with a recruiter named Amanda and she indicated the average salary for long distance driving was $62,400.00 per year (*id.*). They were in the process of recruiting for drivers (*id.*). Next, Mr. Olds contacted Schneider National Trucking Company based out of Green Bay, Wisconsin (Px 1 at 13-14). He indicated Schneider National hired drivers out of Hartford, Connecticut which was 25 miles from Springfield, Massachusetts (Px 1 at 14).
Schneider National was hiring and the average salary for long distance driving was $65,000.00 per year with a one-time $6,000.00 sign on bonus (*id.*). This salary was in line with what Mr. Olds expected to see for someone with Petitioner's work background (Px 1 at 14-15).

Covenant Transportation was the next company Mr. Olds contacted (Px 1 at 15). Covenant was located in Chattanooga, Tennessee but hired drivers out of the Springfield, Massachusetts area (*id.*). He spoke with a recruiter named Judy and she indicated someone with Petitioner's background would make between $62,400.00 and $67,600.00 per year (*id.*). Again, this was in line with what Mr. Olds expected for someone with Petitioner's work background (*id.*).

Lastly, Mr. Olds spoke with a recruiter named Jackie at New Century Transportation based out of West Hampton, New Jersey (Px 1 at 16). They also had jobs in the Springfield, Massachusetts area (*id.*). Jackie indicated to Mr. Olds the salary range for long distance driving was between $60,000.00 to $70,000.00 per year which was in line with what Mr. Olds expected (*id.*). Ms. Bose testified she contacted some of the above but obtained different numbers.

Respondent offered the testimony of Ms. Julie Bose CRC and Michael Wyness from MedVoc Rehabilitation (Rx 2 & Rx 3). Ms. Bose testified she does vocational work for workers' compensation claims and that 80% of that work comes from Respondent's attorneys (Rx 2 at 20). Ms. Bose testified that, based on the Department of Labor Statistics, the average salary for an over the road truck driver in Springfield, Massachusetts was $40,400.00 (Rx 2 at 16). She admitted she did not know how those statistics were tabulated (Rx 2 at 16 & 28).

Mr. Olds further testified the Department of Labor information comes from a survey of group occupations in the driver category meaning their numbers are not tailored or specific for someone like the Petitioner (Px 1 at 22). In fact, he testified that the driver designation is a compilation of 16 jobs. The Arbitrator finds this testimony regarding 16 jobs as a tipping point in the factual determination under 8(d)1 calculations. In the Arbitrator's opinion the DOL information does not appear to focus on the exact credentials and job variables of the worker in the case at bar- which is the case we need to address.

Ms. Bose is by CV a highly experienced and educated CRC in the industry. By admission,, she is not an expert for the area in which Petitioner resides (Rx 2 at 21). She was also unaware of what the different classes were for truck drivers even though this claim revolves around a long distance over the road truck driver with exact trade credentials and experience (Rx 2 at 22-23).

Mr. Wyness, Ms. Bose's employee directed to make calls to contact trucking companies about wages - only asked <u>three</u> questions. The first question asked was "Would you consider hiring an individual with a lengthy history of work as an over the road truck driver and driving instructor?" (Rx 2 at 30-31). This question has no detail in it regarding years of experience, a hazmat endorsement and does not mention the driver goes long distances. See commentary on his testimony by page below.

The next question was then, "what is your anticipated entry level wage?" (Rx 2 at 31). This is asking about an entry level wage and makes no mention of it being for a truck driver with 36 years of experience in long distance driving, commercial drivers license training and a hazmat license. The last question was "are you currently hiring now and/or anticipate hiring within 90 days?" (*id.*). The Arbitrator finds this question has no bearing on what are the earnings in the full performance of his duties per the statute.

Ms. Bose testified that a seasoned over the road truck driver with Petitioner's credentials would only make $5,000.00 to $6,000.00 per year more than a new truck driver with no experience. She also testified that jobs where people are away from home for long periods of time typically pay more. Petitioner travelled across the country and would be away for 3-4 weeks at a time (Tr. 9).

The opinions of Mr. Olds glean the conclusion using the Petitioner- driver's exact credentials. His opinion he could earn in the full performance of his duties between $60,000.00 and $65,000.00 per year. Note the Act, to be precisely construed does not say the "average" of what he could earn, but the "full performance" of his duties.

As for Petitioner's current earning capacity, he has had two separate jobs since his work-injury. He worked first as a truck driving classroom instructor, then as a limo driver and is now again working as a classroom truck driving instructor. He is currently earning $360.00 per week and made less as a limo driver at approximately $270.00 per week (Tr. 28).

Ms. Bose testified Petitioner could presently make $34,167.00 per year as an experienced dispatcher, chauffer or truck driving instructor. Her numbers are based off jobs Mr. Wyness contacted in Illinois. Mr. Wyness did not contact any prospective employers within a reasonable distance of Petitioner's residence in Springfield, Massachusetts (Rx 3 at 17-19).

The actual work history of Petitioner is given far more weight than the testimony and reports of Ms. Bose and Mr. Wyness. Petitioner has worked two separate jobs since his work-injury, one of those jobs twice, and he currently works for The New England Tractor Trailer Training Company making $360.00 per week which is his highest pay since his work-injury (Tr. 31). The Arbitrator deems his current job as suitable gainful employment. He is still able to work as a classroom truck driving instructor a reasonable distance from his home making $360.00 per week.

As to the testimony that is deemed most persuasive both positively and negatively the Arbitrator provides the following cites from the three depositions, to wit:

Mr. Olds- page 8 He has a hazmat and tanker truck endorsement; page 10 the jobs in the report are from the greater Springfield Mass. Area including a west coast driver (65K); page 21 a question of errata may exist whether Ms. Bose research was from Springfield Mo or Mass.
At dep, she did correct herself to Massachusetts; Page 25 Olds testified Ms. Bose report did not take into account of the experience of the driver; page 22 importantly to the Arbitrator, Mr Olds said the DOL driver category actually lists 16 different occupations that they survey- getting an average of those 16 different occupations . So, its not specific to someone like Mr. Pepper.

Page 24 Mr. Olds testified the only explanation he could come up with for such low numbers that Ms. Bose came up with is because she was not asking about over the road traveling across country but rather driving locally. (lines 6-18); Page 25 Olds focused on over the road driving long distances out to the Midwest and out to the west coast a lot going for days and weeks at a time. Mr. Olds "amplified resume" as a deposition exhibit documents for ten years he was a supervisor of regional rehabilitation counselors in Massachusetts- which is the home base of the injured worker.

Ms. Bose testified from a statistics point of view based upon contact with local or regional companies some of which have national routes. Her statistical analysis shows numbers of $40, 937.50 defined in the deposition as a "mean" average. It appears to the Arbitrator that much of the underlying numbers were based upon entry level drivers. The Rx 2-Depostion Exhibit #4 November 1st, 2012 labor market survey appears to this Arbitrator to not having focused on the exact background of this worker at bar and again, geared to a mean or even perhaps more of a median number as a basis of what this person could make in the full performance of his duties.

A tipping point against the persuasiveness of Ms. Bose' testimony is the line of questions and answers in Deposition Rx 2 , page 44, lines 4 through 19. In answer to the question would it not have made more sense to focus on jobs within a reasonable distance of driving from Petitioner's residence , Ms. Bose answered " I don't believe so". .... "If we were looking for work for Mr. Pepper as opposed to just doing a labor market survey, then certainly."
As to this statement in particular, the Arbitrator seeks expert opinion as to the best evidence as to what the worker is capable of earning in the full performance of his duties give the FACTS in this case. The Commission is relying upon experts to provide the best evidence geared to the Petitioner at bar- and this Petitioner was and is now- based upon the east coast.

The testimony of Mr. Wyness from pages 16 through the top of page 16 make it clear that based upon Mr. Bose's questions , he did not focus on the case specific background of Mr. Pepper. When confronted with the question that he did not follow up as to whether the companies he contacted had hubs in Massachusetts, he concluded at page 19 , " that was not a question on the questionnaire" (prepared by Ms. Bose, CRC).

The Arbitrator summarizes as follows: thus, what he is capable of earning by employment based in that region of the country is given the greatest of evidentiary weight. The testimony of CRC Olds is adopted herein not withstanding the top credentials of both CRC.s.

Thus, the Arbitrator makes for material finding of fact based upon the totality of the evidence that Petitioner would be able to earn $62,500.00 per year or approximately $1,200.00 per week in the full performance of his duties in the occupation in which he was engaged at the time of the accident.

Moreover the Arbitrator finds he is now earning $360.00 in some suitable employment or business after the accident. Thus, as a matter of fact and law he is entitled to a weekly wage loss differential in the amount of $560.00 per Section 8(d)1 of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☒ Rate Adjustment Fund (§8(g))
☐ Reverse	☒ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☐ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Dionysios Liarakos,
Petitioner,

vs.

NO: 08 WC 15681

15IWCC0081

Cicero School District #99 and the Illinois State Treasurer, as custodian of the Second Injury Fund,
Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of medical expenses, 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 commencing on the Second July 15th after the entry of this award, the petitioner may become eligible for cost-of-living adjustments, paid by the Rate Adjustment Fund, as provided in Section 8(g) of the Act.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 12, 2014 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

15IWCC0081

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: JAN 30 2015

Mario Basurto

MB/mam
o:12/11/14
43

David L. Gore

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

LIARAKOS, DIONYSIOS
Employee/Petitioner

Case# **08WC015681**

15IWCC0081

CICERO SCHOOL DISTRICT #99 AND THE ILLINOIS STATE TREASURER AS CUSTODIAN OF THE SECOND INJURY FUND
Employer/Respondent

On 5/12/2014, an arbitration decision on this case 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:

0347 MARSZALEK & MARSZALEK
STEVEN A GLOBIS
221 N LASALLE ST SUITE 400
CHICAGO, IL 60601

0863 ANCEL GLINK
ERIN BAKER
140 S DEARBORN 6TH FL
CHICAGO, IL 60603

5120 ASSISTANT ATTORNEY GENERAL
DAVID PAEK
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

STATE OF ILLINOIS 15IWCC0081
)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

DIONYSIOS LIARAKOS
Employee/Petitioner
v.
CICERO SCHOOL DISTRICT #99 and the Illinois State Treasurer, as custodian of the Second Injury Fund
Employer/Respondent

Case # **08** WC **15681**
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 **David Kane**, Arbitrator of the Commission, in the city of **Chicago**, on **4/16/14**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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 15IWCC0081

On **12/21/07**, 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 **$20,621.12**; the average weekly wage was **$396.56**.

On the date of accident, Petitioner was **72** years of age, ***married*** with **0** dependent children.

ORDER

Credits

Respondent shall be given credit for $45,512.60 for TTD benefits paid under Section 8(b) of the Act.

Maintenance

Respondent shall pay Petitioner maintenance benefits of $264.37/week for 37-6/7 weeks, commencing 7/14/09 through 4/4/10, as provided in Section 8(a) of the Act.

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $264.37/week for 79 weeks, commencing 1/8/08 through 7/13/09, as provided in Section 8(b) of the Act.

Permanent Total Disability

Respondent shall pay Petitioner permanent and total disability benefits of **$436.64**/week for life, commencing **4/5/10**, 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.

Medical

See Findings

RULES REGARDING APPEALS UNLESS a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE IF the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

David A. Kane
Signature of Arbitrator

May 12, 2014
Date

MAY 12 2014

STATEMENT OF FACTS

The sole witness that testified before the Arbitrator was the Petitioner, Dionysios Liarakos. He was born on July 9, 1935 in Greece and finished high school there. He came to the United States in 1956 and took English classes for three years. His past employment included work as a clerk for Walgreen's. He also worked as a machine operator, inspector and ultimately a supervisor at Victor Gasket Company. He was self-employed as a commercial painting contractor from 1974 to 1992. From 1992 to 1996 he was a partner in a restaurant and took part in some management duties.

In 2003, he began working for the Respondent as a school bus driver. He was required to have a commercial driver's license and pass a physical every year, which included a vision test.

On December 21, 2007, he was cleaning up his bus. He slipped and struck his right eye on the handle used to open up the bus door. He immediately noted pain in his right eye.

He initially sought treatment with his primary care physician, Dr. William Sarantos on December 27, 2007. He complained of headache and eye pain after being struck in the face at work. He was advised to see an eye doctor. (Petitioner's Exhibit No. 2).

He returned to work on January 7, 2008 and January 8, 2008. He noticed continued right eye pain and the loss of vision in the right eye. He sought treatment at Rezin Eye Center that day and was sent to Comprehensive Eye Care Physicians. January 8, 2008 was the last day he ever worked.

Later on January 8, 2008, Petitioner was seen by Dr. Amy Vanderbrook of Comprehensive Eye Care Physicians. He was diagnosed with giant cell temporal arteritis. He was advised to go to the emergency room at Loyola University Medical Center for emergency steroid treatment. (Petitioner's Exhibit No. 3).

He was treated at Loyola University Medical Center from January 8, 2008 to January 15, 2008. He presented with a history of right-sided headache behind the right eye and blurred vision in the lower outer quadrant of the right eye after being hit in the right eye with a handle. He was diagnosed with giant cell arteritis with a differential diagnosis of trauma. On January 9, 2008, a biopsy was performed of the temporal artery on the right side. The result was negative for temporal arteritis. A CT scan performed on January 11, 2008 was negative. On January 15, 2008, bilateral laser peripheral iridotomies were performed. (Petitioner's Exhibit No. 4).

The Petitioner testified that after his treatment at Loyola he lost vision in his right eye.

On January 23, 2008, he began treatment with Dr. Brian Larsen and Dr. Michael Savitt of Eye Center Physicians, Ltd. Their initial diagnosis was traumatic glaucoma. Petitioner's vision was found to be hand motions only. He was found unable to drive a school bus. Dr. Larsen commented that he will not gain the previous vision in the right eye. On February 10, 2008, Dr. Larsen completed a "Certification of Healthcare Provider" form. The doctor noted: "He currently has lost functional vision from his right eye and can no longer operate a school bus (his occupation) his vision will most likely not improve." On November 12, 2008, Dr. Larsen restricted the

Petitioner from driving commercial vehicles. In a December 4, 2008 letter, Dr. Larson noted that Petitioner had been stable for six months with markedly decreased vision in his right eye with a visual acuity of "count fingers." He indicated that Petitioner requires no further treatment other than biannual routine examinations. His condition was expected not to improve or deteriorate from that point. (Petitioner's Exhibit No. 5 and Respondent's Exhibit No. 1).

Petitioner testified that he saw Dr. Robert Panton on July 13, 2009 at Panton Eye Center. He was referred there by Dr. Sarantos. He sought treatment there because his vision in the left eye was becoming blurred after staring as a computer screen at vocational training. Dr. Panton's diagnosis was acute angle closure glaucoma in the right eye. He noted Petitioner's visual acuity in the right eye was limited to hand motions. He found a severe visual field loss in the right eye. Dr. Panton commented:

> "Mr. Liarakos has profound visual loss in the right eye and would not be eligible for a commercial driver's license (CDL). He also describes eye strain and headaches after computer work lasting over one hour. Since he has a cataract in his only functional eye (the left) we agree with the need for more frequent breaks from prolonged computer or near work." (Petitioner's Exhibit No. 6).

Petitioner received correspondence from the Respondent on February 22, 2008 indicating that due to his injury he is not allowed to return to work until further notification. He was informed, "Cicero

School District No. 99 does not offer light duty or restricted work." (Petitioner's Exhibit No. 7).

Respondent offered into evidence an April 27, 2011, Independent Medical Examination from Dr. Kathryn Duvall. She found Petitioner's right eye had no far vision or close-up vision. She indicated that based on Mr. Liarakos' history of right eye trauma on December 21, 2007, and the absence of any known previous eye conditions, that the subsequent diagnosis of acute angle closure glaucoma could be caused by the eye trauma he described on December 21, 2007. She found his loss of vision in the right eye was irreversible and that he was at maximum medical improvement. (Respondent's Exhibit No. 2).

Petitioner testified that he was assigned vocational placement services by the Respondent with Vocamotive. He met with vocational counselors beginning April 22, 2009 until April 4, 2010. He was tested, given job leads, provided with advice on job searching, and submitted contact logs to Vocamotive counselors.

The evidence deposition of Lisa Helma, a certified vocational counselor with Vocamotive, was taken on January 24, 2013. She testified there was a stable labor market for the Petitioner with available jobs that he would qualify for such as cashier and security guard. (Petitioner's Exhibit No. 15, pg. 25).

On cross-examination, however, Ms. Helma identified several factors that have a detrimental affect on Petitioner's employability including his age (late 70's), 6.3 grade level for arithmetic computation, below average auditory comprehension, below average ability to identify and correct errors and few transferable work skills

from his pre-injury employment. (Petitioner's Exhibit No. 15, pgs. 27-30).

The testing also demonstrated that the Petitioner did not meet a competitive production standard on most testing and jobs under consideration would likely require employer understanding and accommodation. (Petitioner's Exhibit No. 15, pgs. 30-31).

Ms. Helma testified that under her supervision Petitioner contacted hundreds and possibility over a thousand job search contacts and never received an offer of employment. She testified he was fully cooperative with the job search effort. (Petitioner's Exhibit No. 15, pg.33).

Her opinion that Petitioner was employable, was based solely on Dr. Larsen's restriction that he cannot drive a school bus or do commercial driving. She was instructed by Shirley McGill, the adjuster from X-Changing to ignore Petitioner's other restrictions, specifically Dr. Panton's restriction that he have frequent breaks from prolonged computer or near work. (Petitioner's Exhibit No. 15, pgs. 34-35).

Ms. Helma concluded that taking into consideration all of Mr. Liarakos' limitations that, "I don't believe there is an access to a labor market for Mr. Liarakos." (Petitioner's Exhibit No. 15, pg. 35).

IN SUPPORT OF THE ARBITRATOR'S DECISION RELATING TO (K) AND (L), THE ARBITRATOR FINDS THE FOLLOWING FACTS:

The Petitioner has a 100% loss of use of his right eye as a result of the accident of December 21, 2007, based upon the records of Dr. Larsen, Dr. Panton and the report of Dr. Duvall. All of these doctors report Petitioner's vision is at best being able to detect hand motions. He has not worked since January 8, 2008. His employer will not take him back to work as a bus driver or in any other light duty capacity. He has restrictions of no bus driving or commercial driving from Dr. Larsen and the requirement for frequent breaks from computer work or near work from Dr. Panton. He has done an extensive job search with Vocamotive and on his own and has been unable to obtain employment. Respondent's vocational counsel, Lisa Helma, has testified that considering all of Petitioner's limitations, there is no access to a labor market for him.

Based upon the above, the Arbitrator concludes that it has been proven by the preponderance of evidence that no reasonably stable labor market exists for the Petitioner considering his age, disability, work experience, training, skills, education and capabilities and therefore he is permanently and totally disabled pursuant to E. R. Moore v. Industrial Commission, 71 Ill.2d 353 (1978).

On the Request for Hearing form, Respondent contended that Petitioner was temporarily and totally disabled until March 28, 2012. The Petitioner claimed that he was temporarily and totally disabled

from January 8, 2008 through July 13, 2009 and entitled to maintenance from July 14, 2009 through April 4, 2010.

On December 4, 2008, Dr. Larsen found that Petitioner's condition was stable and that he required no further treatment. (Respondent's Exhibit No. 1).

On July 13, 2009, Petitioner sought treatment with Dr. Robert Panton of Panton Eye Center with complaints of eye strain and headaches and computer work lasting over one hour. Dr. Panton felt Petitioner needs more frequent breaks from prolonged computer or near work. Petitioner received no further treatment other than routine checks from Dr. Larsen after July 13, 2009. (Petitioner's Exhibit No. 6).

From July of 2009 to April 4, 2010, Petitioner was working with vocational rehabilitation counselors from Vocamotive receiving job search testing, training and performing a monitored and assisted job search. (Petitioner's Exhibit No. 15, pg. 27).

Based upon the above, the Arbitrator concludes that Petitioner was temporarily and totally disabled from January 8, 2008 through July 13, 2009. He is entitled to maintenance from July 14, 2009 through April 4, 2010 when he was working with Vocamotive. He is found to be permanently and totally disabled from April 5, 2010.

IN SUPPORT OF THE ARBITRATOR'S DECISION RELATING TO (J), THE ARBITRATOR FINDS THE FOLLOWING FACTS:

Respondent stipulated on the record to liability for Petitioner's medical expenses related to treatment for his right eye. Consequently, the Arbitrator finds Respondent liable for the following:

Petitioner's Exhibit No. 8, Loyola Medical Center, charges totaling, $13,616.36; Respondent shall pay to the Petitioner $8,008.54 representing payments made by Medicare. Respondent shall hold Petitioner safe and harmless for $12,807.82 paid by BlueCross/BlueShield, Respondent's group carrier.

Petitioner's Exhibit No. 9, Loyola Physician Specialty Services, charges totaling $7,981.80; Respondent shall pay to the Petitioner $133.50 paid by Medicare. Respondent shall hold Petitioner safe and harmless for $2,482.60 paid by the group carrier, BlueCross/BlueShield.

Petitioner's Exhibit No. 10, Eye Care Physicians Ltd., charges totaling $377.00; Respondent shall pay to the petitioner $15.11 paid by Medicare. Respondent shall hold Petitioner safe and harmless for $30.00 paid by BlueCross/BlueShield.

Petitioner's Exhibit No. 11, Walmart Pharmacy, for Lisinopril, $191.91. Respondent shall pay $191.91 to the Petitioner.

Petitioner's Exhibit No. 14, Comprehensive Eye Care Physicians, charges, $328.00. Respondent shall hold Petitioner safe and harmless for $313.00 paid by BlueCross/BlueShield. Respondent shall pay to the Petitioner a balance of $15.00.

IN SUPPORT OF THE ARBITRATOR'S DECISION RELATING TO (M), THE ARBITRATOR FINDS THE FOLLOWING FACTS:

The Arbitrator declines to impose penalties and attorney's fees on Respondent based on its failure to pay compensation after Petitioner had clearly reached Maximum Medical Improvement and further compensation was as yet to be adjudicated. The Arbitrator does not believe that Respondent's failure to pay further compensation was unreasonable and vexatious or without good and just cause, although the Arbitrator has awarded the requested compensation to Petitioner.

Penalties and attorney's fees are hereby denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF MCLEAN)

☐ Affirm and adopt	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☒ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

CLAYTON ROSS,

Petitioner,

15IWCC0082

vs.

NO: 13 WC 012633

CROSS FARMS, INC.,

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 and temporary total disability and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

The Decision of the Arbitrator held Respondent liable for $170,962.47 for the medical services provided to Petitioner. It is found the medical charges the Arbitrator relied upon to determine the award had not been adjusted pursuant to the fee schedule. The Commission finds, when the fee schedule is applied, the amount Respondent is liable for is $48,956.02.

All other issues are affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $403.10 per week for a period of 64-3/7 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

15IWCC0082

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 the sum of $125.00 per week for a period of 6-3/7 weeks as provided in Section 8(a) of the Act

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $48,956.02 for medical expenses under §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

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: JAN 30 2015
kwl/mav
O: 12/02/14
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

15IWCC0082

ROSS, CLAYTON
Employee/Petitioner

Case# **13WC012633**

CROSS FARMS INC
Employer/Respondent

On 1/15/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% 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:

1189 WOLTER BEEMAN AND LYNCH
BRENT A BEEMAN
1001 S 6TH ST PO BOX 5276
SPRINGFIELD, IL 62705

2674 BRADY CONNOLLY & MASUDA PC
JULIA McCARTHY
705 E LINCOLN ST SUITE 313
NORMAL, IL 61761

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
19(b) ARBITRATION DECISION

CLAYTON ROSS

Petitioner,

v.

CROSS FARMS, INC.,

Respondent.

15IWCC0082

IWCC Case No.: 13C-12633

MEMORANDUM OF DECISION OF ARBITRATOR

An Application For Adjustment of Claim was filed in this matter, and a Notice of Hearing was mailed to each party. Pursuant to a Stipulation by both parties, the matter was heard by the Honorable, Arbitrator Stephen Mathis, in the City of Bloomington, on November 14, 2013. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES:

F. **Is the Petitioner's present condition of ill-being causally related to the injury?**

J. **Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?**

K. **Is Petitioner entitled to any prospective medical care?**

L. **What temporary benefits are in dispute? TTD. TPD. Medical Compensation.**

N. **Is Respondent due any credit?**

FINDINGS:

On 6/28/12, Respondent was operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship did exist between Petitioner and Respondent.

On this date, Petitioner did sustain an accident that arose of and in the course of employment.

Timely notice of this accident was given to Respondent.

Petitioner's current condition of ill-being is causally related to the accident.

In the year preceding the injury, Petitioner earned $31,440.00; the average weekly wage was $604.62.

On the date of accident, Petitioner was 31 years of age, married with 2 children under 18.

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 is entitled to a credit for temporary total disability and 1,813.82 for a PPD advance under Section 8(j) of the Act.

ORDER:

The Respondent shall pay the Petitioner temporary total disability benefits of $403.10 per week for 64 3/7 weeks, from July 5, 2012 to October 1, 2013; as provided in Section 8(b) of the Act, because the injuries sustained caused the disabling condition of the Petitioner. Respondent is owed a credit of $16,123.20 for payments of temporary total disability benefits.

Respondent shall pay Petitioner temporary partial disability benefits of $125.00 a week for 6 3/7 weeks, commencing 10/1/13 through 11/14/13, as provided in Section 8(a) of the Act.

The Respondent shall pay $170,962.47 for medical services as provided in Section 8(a) and 8.2 of the Act. Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

RULES REGARDING APPEALS. Unless a party files a Petition For Review within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE. If the Commission reviews this award, interest at the rate set forth on the Notice of Decision of Arbitrator shall accrue from the date listed below to the date before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

S J Mathis
Signature of Arbitrator

1-2-14
Date

JAN 15 2014

ILLINOIS WORKERS' COMPENSATION COMMISSION

19(b) ARBITRATION DECISION

CLAYTON ROSS Petitioner, v. CROSS FARMS, INC., Respondent.	)	15IWCC0082 IWCC Case No.: 13C-12633

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner has been employed by Respondent since 2008 as a truck driver. (T 13). It is undisputed that on June 28, 2012, while in the course and scope of his duties for Respondent, Petitioner was involved in a high speed motor vehicle accident. Petitioner was traveling on Route 116 in Peoria County, at approximately 8:04, when a 2006 Ford Explorer crossed the center line and entered his lane of traffic colliding with Petitioner's semi-truck. The impact forced Petitioner's semi-truck into a ditch on the side of the road way. (PX 12) Photographs taken of Petitioner's semi-truck following the accident show a significant amount of damage to the cab area of Petitioner's truck. (PX 16) Petitioner testified at the Arbitration hearing that prior to the accident the condition of his neck, back and legs were asymptomatic. (T 14). Respondent did not produce any evidence to contradict Petitioner.

Petitioner began his treatment the same day as the motor vehicle accident at Abraham Lincoln Memorial Hospital Emergency Room with complaints of low back pain, neck pain and headache. (PX 5).

Petitioner felt his pain symptoms increase in the days following the accident (T 23). He attempted to go back to work on July 5, 2012, but was unable to do so. Respondent made an appointment for him at Springfield Clinic where he was treated by Dr. Ingram. (T 25). Treatment records reveal that Petitioner was having back pain that was getting worse and he complained of neck pain as well. He was taken off of work from July 5, 2012 through July 6, 2012. (PX 4)

On July 8, 2012, Petitioner sought treatment at OSF St. Joseph Healthcare Emergency Room complaining of back pain from the motor vehicle accident. He described the pain as stabbing and shooting, radiating pain down both legs to the knees. Petitioner stated he was having trouble walking or standing for longer than 30 minutes and was having severe pain and swelling in the bilateral lower extremities. Petitioner was released from work until cleared by Occupational Health. (PX 3),

OSF St. Joseph Occupational Health managed Petitioner's care from July 9, 2012, to August 24, 2012 by prescribing medications, sending Petitioner to physical therapy and referring him to specialists. Petitioner was seen at OSF Occupational Health with low back pain radiating down his bilateral legs. He was released to return to work on July 9, 2012, with the restrictions of no repetitive bending, stooping or twisting and no lifting more than 10 pounds, sedentary work only and was specifically forbidden to drive a semi. (PX 2 work status worksheet dated 7-9-12) On July 12, 2012, Petitioner underwent an MRI of his lumbar spine with the findings of an L2/3 loss of disc concavity, an L3/4 loss of disc concavity, and an L4/5 loss of disc concavity. In addition, the MRI showed a focal left foramina disc protrusion in an inferior aspect of the neural foramin. (PX 1K).

On July 26, 2012, Petitioner was referred to Dr. Pegg by Occupational Health. Dr. Pegg stated that the history and exam would be consistent with an right L5 radiculopathy and ordered an EMG. Petitioner was again seen by Dr. Pegg on August 7, 2012. Dr. Pegg interpreted the EMG exam as being normal and referred Petitioner back to occupational health, FOR additional physical therapy and medications. (PX 8).

Following his second visit with Dr. Pegg, Occupational Health continued Petitioner's work restrictions of no repetitive bending, stooping or twisting; no static chronic bent postures, no lifting more than 10 pounds, with sedentary work only, and with the instructions of specifically not driving a semi. Further, OSF Occupational Health referred Petitioner to McLean County Orthopedics, specifically Dr. Carmichael. (PX 2).

Dr. Carmichael continued to restrict Petitioner's work, specifically stating that Petitioner should not lift over 10 pounds frequently or 20 pounds occasionally, no repetitive lifting bending or twisting; no prolonged sitting and should be able to sit or stand as needed.(PX 7, note of 8-24-12). On September 4, 2012, Petitioner was referred by Dr. Carmichael to the Center of Outpatient Medicine for an right L4/5 discogram with intradiscal cortisone injection and a right L4/5 and L4 transforaminal epidural injection. After these injections did not provide significant improvement, Dr. Carmichael recommended another epidural injection and a surgical consult (PX 6, 7). Petitioner testified at the arbitration hearing that Dr. Carmichael originally wanted to refer him to Dr. Atwater for his surgical consult but Dr. Atwater was unavailable at the time. Due to this unavailability, Dr. Carmichael referred him to Dr. Seibly, who recommended additional physical therapy and stated that if the physical therapy fails, he would suggest consideration of a median nerve branch block of the lumbar spine but did not consider Petitioner to be a surgical candidate at the time. He deferred his future medical care back to Dr. Carmichael. (T31-33) (PX 9).

After discussing Dr. Seibly's recommendations, Dr. Carmichael referred Petitioner to Dr. Atwater who read Petitioner's MRI and noticed an annular tear at L4/5 with mild generative disc at the neuroforamin at L4/5. In addition, Dr. Atwater noticed that the left neuroforamin compromise and recommended surgery. He also recommended an additional MRI. On May 14, 2013, Petitioner underwent a second MRI of the lumbar spine which revealed a minimal deminuation of disc height with disc dessication at L4/5, minimal disc dessication relative to the height preservation at T12/L1 and T11/12, L5/S1 minimal left greater than right facet hypertrophic change, left foraminal disc extrusion without significant impression, and the

foramin exiting the L4 nerve root. On June 21, 2013, Petitioner underwent surgery at Advocate Bromenn Medical Center, specifically, a posterior decompression discectomy with the facetectomy at L4/5, transforaminal lumbar interbody fusion L4/5, posterior instrumentation at L4/5, posterolateral arthrodesis L4/5, biological insert placement of a Nuvasive 12 x 9 x 5 cage and allograft or autograft, and Intraoperative neuromonitoring by neuromonitoring services. (PX 13). Dr. Atwater took Petitioner off work due to his injuries (PX 11 Pg. 13).

Following surgery, Dr. Atwater referred Petitioner to Hopedale Rehabilitation for rehabilitation following the surgery. At the arbitration hearing on November 14, 2013, Petitioner testified that he felt the surgery provided more relief than the injections or physical therapy he underwent prior to the surgery. After completing his rehabilitation at Hopedale Rehabilitation, Petitioner continues to treat with Dr. Atwater for follow up visits. (T 37,38)

In addition to the treatment records described above, the Evidence deposition of Petitioner's board certified treating Orthopedic surgeon John G. Atwater on September 5, 2013. (PX 11). Dr. Atwater testified that he had treated Petitioner on multiple occasions, and to a reasonable degree of medical certainty that Petitioner suffered an injury on June 28, 2012. (PX 11 Pg. 16,17). Dr. Atwater further testified to a reasonable degree of medical certainty, Petitioner's current condition of ill being is causally related to his work injury, that his care and treatment of Petitioner was reasonable and necessary, and that he kept Petitioner off of work and restricted his work due to his work injury of June 28, 2012. (PX 11 Pg. 17,18).

Respondent introduced the evidence deposition and independent medical exam report of its section 12 expert Steven Mather M.D. Dr. Mather testified that he saw Petitioner on a single occasion on March 18, 2013. Dr. Mather concluded that Petitioner suffered a lumbar strain in the accident and that he has psychogenic pain/functional overlay, was at maximum medical improvement, required no further medical treatment and may return to work with no restrictions. (RX 1)

Petitioner testified at the arbitration hearing that he been off of work or had work restrictions which the Respondent has not accommodated since July 5, 2012. On September 26, 2013, Dr. Atwater lessened his work restrictions to six hours a day with a 25 pound lifting restriction, and no repetitive lifting or bending. (PX 7, 10). He has found work through a friend which pays approximately $125.00 a week. (T 40, 41). Petitioner last treated with Dr. Atwater on November 13, 2013. His current work restrictions are work limit of 8-10 hours, no lifting over 30 pounds, no repetitive lifting, bending or standing. (T 38, 39) (PX 10).

CONCLUSIONS OF LAW

In support of the Arbitrator's Decision with regard to "F. Is the Petitioner's present condition of ill-being causally related to the injury?:

The undisputed evidence presented at the Arbitration hearing on November 14, 2013, suggests that Petitioner was healthy and asymptomatic with regard to his neck back and legs prior to the automobile accident on June 28, 201(T 14). The Fourth Circuit has recently cited the Illinois Supreme Court in establishing that "the 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 the causal nexus between the accident and the employee's injury." **Shaffer v. IWCC, 2011 Ill. App. 4th 100505 WC, 976 N.E.2d 1, 364 Ill. Dec. 1 (4th Dist. 2011) citing International Harvester v. Ind. Comm., 93 Ill. 2d 59, 442 N.E.2d 908 (1982).**

In the present case, following Shaffer, the evidence is clear that Petitioner was asymptomatic prior to his automobile accident, he initiated treatment later that day and has consistently treated for his injuries since the accident and continues to treat with Dr. Atwater for his injuries. The arbitrator notes that Respondent has provided no evidence that Petitioner treated for his back or legs prior to this motor vehicle accident of June 28, 2012, and did not present any evidence that he suffered a subsequent injury after June 28, 2012.

Dr. John G. Atwater, Petitioner's board certified treating orthopedic surgeon, testified in his evidence deposition that Petitioner suffered an injury on June 28, 2012, that was causally related to the onset of his pain, disc herniation or annular tear, and that all of the treatment he was given to Petitioner relates to the motor vehicle accident of June 28, 2012. (PX 11, Pg. 17-18) The arbitrator finds the testimony of Dr. Atwater to be more credible than that of Respondent's section 12 expert, Dr. Mather, for several reasons. First, Respondent's section 12 expert bases his opinions, in part, on the false assumption that Petitioner did not report left leg symptoms until the results of his MRI taken on July 12, 2012 were known and later claims Petitioner did not report left leg symptoms until four to five months post-accident (RX 1, dep. Ex. 2, exhibit 5). The evidence clearly reveals that Petitioner reports bilateral leg pain as early as July 8 and 9 2012 which each pre date Petitioner's first MRI (PX 2, 3, 1K). Next, Respondent's Section 12 expert, cites an article as the basis for his conclusion entitled "Evolution of Late Whiplash Syndrome Outide the Medical-Legal Context" which involves a study of low speed rear end collisions and neck injuries, which is clearly different that Petitioner's crash. (RX 1, Pg. 35, 36). Additionally, Dr. Atwater explains in his deposition that he had both objective and subjective findings in his physical examinations, (PX 11 Pg. 25), which contradicts Dr. Mather's conclusions. (R. EX 1 dep ex 2). Finally, the arbitrator notes that Dr. Atwater, despite treating Petitioner on multiple occasions, found no evidence of him faking his injuries or magnifying his symptoms (PX 11 Pg. 22). The arbitrator finds this opinion to be more credible than Dr. Mather's section 12 opinion regarding symptom magnification because Dr. Atwater saw him on more occasions.

For the reasons stated above, the Arbitrator finds that Petitioner's current condition of ill-being is causally related to the accident.

In support of the Arbitrator's Decision with regard to "J. Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?":

Petitioner's Exhibits 1A through 1N, and 2, 3, 4, 5, 6, 7, 8, 9, 13, and 14; and Respondent's Exhibit 4, detail Petitioner's injuries.

The medical services provided by OSF Occupational Health, OSF St. Joseph Hospital, Springfield Clinic, Abraham Lincoln Memorial Hospital, Center for Outpatient Medicine, Empire Anesthesia, Dr. Carmichael, McLean County Orthopedics, Dr. Atwater, Walgreens, Bloomington Radiology, Dr. Pegg, Dr. Jason Siebly, Fort Jesse Imaging, OSF Medical Group, Dr. Nord, emergency room physician, pathology, Hopedale Rehabilitation, Bromenn Hospital, and McLean County Anesthesiology; were reasonable and necessary considering Petitioner's symptomology and history of injury. In addition, the prospective medical treatment recommended by Petitioner's treating physicians and providers, is reasonable and necessary.

Dr. John G. Atwater specifically stated in his evidence deposition that his care and treatment, including surgery was reasonable and necessary. (PX 10, Pg. 22)

After viewing Petitioner's Exhibits, it appears that Respondent has not paid all of the appropriate charges for all reasonable and necessary medical services, which include the bills of:

OSF Occupational Health	7/9/12	$194.25
	7/12/12	$2,190.08
	7/13/12	$103.47
	7/16/12	$195.15
	7/18/12	$109.00
	7/20/12	$113.91
	7/23/12	$25.95
	7/25/12	$25.95
	7/27/12	$25.95
	8/1/12	$62.27
	8/14/12	$113.91
	5/14/13	Unknown
St. Joseph Hospital	7/8/12	$929.70
	5/4/13	$3,722.00
Springfield Clinic	7/5/12	$140.00
	7/5/12	$454.00
Abraham Lincoln Memorial Hospital	6/28/12	$469.31
Center for Outpatient Medicine/		
Empire Anesthesia/Dr. Carmichael	9/4/12	$1660.00
	9/4/12	$1660.00
	9/4/12	$1660.00
	9/4/12	$403.00
	9/4/12	$595.00
	10/1/12	$2,063.00
	10/1/12	$1660.00
	10/1/12	$550.00
	6/21/13	$4,200.00
McLean County Orthopedics		
Dr. Atwater	8/24/12	$262.00
	9/4/12	$1,514.00
	9/4/12	$1,685.00

	9/4/12	$895.00
	9/4/12	$405.00
	9/18/12	$111.00
	10/1/12	$3,370.00
	11/8/12	$111.00
	2/6/13	$291.00
	2/6/13	$161.00
	4/12/13	$123.00
	5/2/13	$96.00
	5/2/13	$1,050.00
	6/21/13	$1,004.00
	6/21/13	$20,337.00
	6/21/13	$6,175.00
	6/21/13	$3,859.00
	6/21/13	$7,699.00
	6/27/13	$200.00
	7/31/13	$200.00
	8/28/13	$200.00
	9/26/13	$200.00
Walgreens	7/5/12	$17.99
	7/8/12	$83.24
	7/8/12	$14.74
	7/8/12	$25.99
	7/9/12	$11.99
	7/13/12	Unknown
	7/20/12	$11.99
	7/30/12	Unknown
	6/17/13	Unknown
	7/31/13	$2.00
Bloomington Radiology	7/8/12	$48.00
	5/14/13	$471.00
	6/11/13	$46.00
	6/21/13	$96.00
Dr. Pegg	7/26/12	$359.00
	8/7/12	$2,585.00
Dr. Jason Seibly	10/29/12	$236.00
Fort Jesse Imaging	7/12/12	$2,067.00
OSF Medical Group/Dr. Nord	6/17/13	$314.00
Bromen Medical Center	6/21/13 to 6/23/13	$85,826.98
	6/11/13	$1,041.00
(ER Physician)	7/8/12	$387.00
(Pathology)	6/21 to 6/23/13	$33.40
Hopedale Rehabilitation	7/15 to 8/29/13	$2,766.25
McLean County Anesthesiology	9/4/12	$686.00
	10/1/12	$588.00

The Respondent shall pay $170,962.47 plus unknown charges as indicated above for medical services as provided in Section 8(a) and 8.2 of the Act.

Respondent shall be given a credit for medical bills it has paid. Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

In support of the Arbitrator's Decision with regard to "K. Is Petitioner entitled to any prospective medical care?"

Petitioner continues to treat for his back for the injuries he sustained on June 28, 2012. Petitioner testified at the arbitration hearing on November 14, 2013, that he continues to treat with Dr. John G. Atwater for his back and has an appointment for a follow up him. (T 38). Further, Dr. Atwater testified in his deposition that he would recommend a functional capacity evaluation. (PX 10, Pg. 20.)

Based on the above facts, the Arbitrator finds that Petitioner is entitled to prospective medical care at the direction of Dr. Atwater.

In support of the Arbitrator's Decision with regard to "L. What temporary benefits are in dispute?":

Petitioner testified at the arbitration hearing that he been off of work or had work restrictions which the Respondent has not accommodated since July 5, 2012. (T 39,40). Respondent did not produce any evidence that it attempted to accommodate Petitioner's restrictions. In addition, Petitioners testimony is corroborated by numerous off work slips and work restrictions between July 5, 2012 and November 13, 2013 (PX 4, 3, 7, 10, 11). No treating physicians corroborate the Section 12 physician's opinion that he can work full duty.

On September 26, 2013, Dr. Atwater lessened his work restrictions to six hours a day with a 25 pound lifting restriction, and no repetitive lifting or bending. (PX 7, 10). He has found work through a friend which pays approximately $125.00 a week beginning on October 1, 2013. (T 40, 41). Petitioner last treated with Dr. Atwater on November 13, 2013. His current work restrictions are work limit of 8-10 hours, no lifting over 30 pounds, no repetitive lifting, bending or standing. (T 38, 39) (PX 10).

Based on the above facts, the Arbitrator finds that pursuant to Section 8(b) of the Act, the Petitioner was temporarily and totally disabled from July 5, 2012, to October 1, 2013, and temporarily partially disabled from October 2, 2013 and the date of the arbitration hearing on November 14, 2013.

In support of the Arbitrator's Decision with regard to "N. Is the Respondent due any credit?":

The Arbitrator finds that Respondent is due a credit for temporary total disability that has been paid previously, medical bills that it has paid and for the PPD advance it provided in order to delay Petitioner's original trial date.

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 Down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Alison Lowery,

Petitioner,

15IWCC0083

vs.

NO: 13 WC 10888

Kansas Community Unit School District 3,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent and Petitioner herein and notice given to all parties, the Commission, after considering the issue of prospective medical treatment and being advised of the facts and law, modifies the Decision of the Arbitrator to reverse the award of prospective medical treatment 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 compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Commission*, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

Petitioner, a 33-year-old special education teacher, filed an Application for Adjustment of Claim alleging injuries to her left shoulder resulting from a physical altercation with a student on April 1, 2011. Petitioner testified that she was struck multiple times in the left shoulder while trying to restrain the student using both arms. Respondent accepted liability and authorized surgery to repair a labral tear. Dr. Ulrich performed arthroscopic surgery on June 22, 2011; the post-operative diagnosis was a type II SLAP labral tear. Petitioner participated in physical therapy and returned to full duty work in August of 2011. She was discharged from physical therapy on October 14, 2011 having completed all treatment goals and reporting no pain or complaints with respect to using her left shoulder. Petitioner was last seen by Dr. Ulrich on

November 4, 2011. He found that Petitioner had reached maximum medical improvement for the injury and he released her from care. Dr. Ulrich's treatment records during the last few visits note Petitioner's nonspecific complaints unrelated to the left shoulder, such as muscle cramping and weakness, joint pain, back pain and stiffness, headaches, and numbness and tingling.

Petitioner sought no medical treatment for her left shoulder after her November 2011 release from Dr. Ulrich until December of 2012. On August 20, 2012, Petitioner saw a nurse practitioner at the office of her primary care physician with work-related stress concerns. Petitioner reported that it was the first day of school and that she was extremely unhappy with her job and could not go to work; however, no complaints of left upper extremity symptoms were noted. Petitioner returned to the nurse practitioner on September 25, 2012 with additional stress and work-related complaints. Petitioner reported that she was actively looking for a new job. Again, no current complaints with respect to the left upper extremity were noted. On December 12, 2012 Petitioner saw her primary care physician, Dr. Spicklemire, and complained of dull, achy left shoulder pain at a level of three out of ten for the past six months, in addition to worsening symptoms of depression and anxiety. Dr. Spicklemire diagnosed post-operative soreness exacerbated by the cold weather, and he prescribed antidepressants and Tylenol.

On January 23, 2013, Petitioner was examined by Dr. Nogalski at the request of Respondent. Dr. Nogalski opined that Petitioner had mild pain in her left shoulder that would reasonably be related to her post-surgical status, but that she was at maximum medical improvement for her left shoulder and no further treatment was necessary.

Approximately fifteen months after her release from Dr. Ulrich, Petitioner was examined by a shoulder specialist, Dr. Sallay. Petitioner agreed that between her release from Dr. Ulrich on November 4, 2011 and her initial examination by Dr. Sallay on April 29, 2013 she never returned to Dr. Ulrich. However she testified that she continued to have symptoms of pain, weakness, numbness and tingling and difficulty using her left hand during that time. At her examination by Dr. Sallay, Petitioner reported achy pain in the biceps and numbness and tingling in the entire left upper extremity. Dr. Sallay concluded that Petitioner had some rotator cuff weakness and recommended physical therapy; he believed that Petitioner's neurological complaints appeared to be consistent with carpal tunnel syndrome. Dr. Sallay did not recommend any orthopedic intervention with respect to the left shoulder but he referred Petitioner to his partner Dr. Rettig, a hand and wrist specialist, for further evaluation of her neurological symptoms.

Dr. Rettig examined Petitioner on the same day, April 29, 2013. He noted that Petitioner complained of left wrist numbness and pain, stiffness, weakness, numbness and tingling and difficulty performing fine motor activities like typing and crocheting. Dr. Rettig diagnosed potential carpal tunnel syndrome or cubital tunnel syndrome and recommended an EMG and use of a splint. After the EMG on May 29, 2013 Petitioner was reexamined by Dr. Rettig. Petitioner complained of pain in the left shoulder and left upper extremity as a result of having undergone the EMG; Dr. Rettig noted the results of the EMG were essentially negative. An MRI of the left

shoulder showed Petitioner's labral repair to be intact. Dr. Rettig suspected that Petitioner had developed complex regional pain syndrome ("CRPS") in her left upper extremity and he prescribed Neurontin. Dr. Rettig recommended further evaluation by a specialist in pain management and the treatment of CRPS, and he indicated that a stellate ganglion nerve block for diagnostic and therapeutic purposes may be beneficial. Dr. Rettig stated in the July 29, 2013 record and reiterated in his deposition testimony that he believed the diagnosis of probable CRPS was related to Petitioner's work injury, although he found it "a rather uncommon sequela from this injury and surgery." Dr. Rettig admitted during his deposition testimony that Petitioner did not have all of the classic signs and symptoms of CRPS, such as hypersensitivity, temperature changes, loss of hair, skin or nail changes or discoloration. He also agreed that Petitioner may have mild carpal tunnel syndrome "as part of a larger, neurologic-type picture." He relied on Petitioner's history that she had no prior left upper extremity complaints before the accident in finding that Petitioner's current condition of ill-being and need for further assessment and treatment is related to the accident of April 1, 2011.

Petitioner was reexamined by Dr. Nogalski on October 2, 2013. Dr. Nogalski also reviewed Petitioner's updated medical records and diagnostic studies. He found that Petitioner had mild to moderate carpal tunnel syndrome and possibly mild ulnar neuropathy or cervical radiculopathy. He reiterated his opinion that Petitioner was at maximum medical improvement with respect to the shoulder. He did not believe that Petitioner had signs and symptoms consistent with CRPS and he did not believe that Petitioner's current complaints were related to the work injury.

Respondent agreed that medical treatment through November 4, 2011 was reasonable, necessary and related to the accident of April 1, 2011. Respondent disputed liability for additional medical treatment based on a lack of causal connection to the April 1, 2011 accident. Respondent relied on the credibility of Petitioner's treatment records and release by Dr. Ulrich and the further opinions of Dr. Nogalski. Petitioner testified at hearing that she is still working full duty as a special education teacher, but is now in a different school district. She testified that she has severe pain when she does not take Neurontin and notices that she has difficulty performing fine motor activities and overhead activities due to symptoms of weakness, numbness and tingling.

The Arbitrator found that Petitioner proved causal connection between her current left upper extremity condition and the accident and awarded medical expenses and prospective medical treatment including prescriptions for Neurontin and the stellate ganglion nerve block recommended by Dr. Rettig. The Arbitrator found that Respondent's reliance on Dr. Nogalski's opinion was reasonable and not in bad faith and did not award penalties and fees with respect to Respondent's refusal of authorization for prospective medical treatment.

After reviewing all of the evidence, we conclude that Petitioner reached maximum medical improvement for her work related injury as of November 4, 2011 and no causal connection exists between the current condition of ill-being alleged by Petitioner and the

15IWCC0083

April 1, 2011 left shoulder injury. We find the evidence is insufficient to prove that Petitioner's current upper left extremity symptoms are the result of the accident and not idiopathic causes and we reverse the Arbitrator's award of prospective medical treatment. We note that Drs. Rettig, Sallay and Nogalski are not specialists in the areas of CRPS or neurosurgery. No persuasive evidence of medical causation has been shown between Petitioner's discrete left labral tear and the current nerve pathology in her forearm, hand and possibly her cervical spine. We further note that the medical records do not support Petitioner's testimony that she never completely recovered after the surgery performed by Dr. Ulrich in June of 2011. We note that Petitioner had no specific complaints of neuropathic pain with respect to her left upper extremity throughout her treatment with Dr. Ulrich. In conclusion, we find that Petitioner reached maximum medical improvement as of November 4, 2011 and is entitled to an award of permanent partial disability with respect to the left shoulder injury of April 1, 2011, and we remand this case to the Arbitrator for further findings on the nature and extent of the injury.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's award of prospective medical treatment is hereby reversed for the reasons set forth above.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings on the issue of the nature and extent of the injury, 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.

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: JAN 30 2015
RWW/plv
o-12/2/14
46

Ruth W. White

Charles J. DeVriendt

Daniel R. Donohoo

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) DECISION OF ARBITRATOR

LOWERY, ALISON
Employee/Petitioner

Case# **13WC010888**

KANSAS COMMUNITY UNIT SCHOOL DISTRICT 3
Employer/Respondent

15IWCC0083

On 4/22/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% 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:

0143 CRAIG & CRAIG LLC
JOHN BARGER
PO BOX 689
MATTOON, IL 61938

1337 KNELL & KELLY LLC
PATRICK JENNETTEN
504 FAYETTE ST
PEORIA, IL 61603

15IWCC0083

STATE OF ILLINOIS)
)SS.
COUNTY OF CHAMPAIGN)

- ☐ Injured Workers' Benefit Fund (§4(d))
- ☐ Rate Adjustment Fund (§8(g))
- ☐ Second Injury Fund (§8(e)18)
- ☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Alison Lowery
Employee/Petitioner

v.

Kansas Community Unit School District 3
Employer/Respondent

Case # 13 WC 10888

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 Urbana, on March 25, 2014. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ Is Petitioner entitled to any prospective medical care?
L. ☐ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☐ TTD
M. ☒ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On the date of accident, April 1, 2011, Respondent was operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship did exist between Petitioner and Respondent.

On this date, Petitioner did sustain an accident that arose out of and in the course of employment.

Timely notice of this accident was given to Respondent.

Petitioner's current condition of ill-being is causally related to the accident.

In the year preceding the injury, Petitioner earned $39,946.48; the average weekly wage was $1,079.63.

On the date of accident, Petitioner was 33 years of age, married with 2 dependent child(ren).

Respondent has not paid all reasonable and necessary charges for all reasonable and necessary medical services.

Respondent shall be given a credit of $0.00 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $0.00.

Respondent is entitled to a credit of $0.00 under Section 8(j) of the Act.

ORDER

Respondent shall pay/reimburse reasonable and necessary medical services as identified in Petitioner's Exhibits 8, 9 and 10 as provided in Sections 8(a) and 8.2 of the Act subject to the fee schedule.

Respondent shall authorize and make payment for prospective medical treatment including, but not limited to, prescriptions for Neurontin and a stellate ganglion block as recommended by Dr. Arthur Rettig.

Based upon the Conclusions of Law attached hereto, Petitioner's claim for Section 19(k) and 19(l) penalties and Section 16 attorneys' fees is denied.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

William R. Gallagher, Arbitrator
ICArbDec19(b)

April 14, 2014
Date

APR 22 2014

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 April 1, 2011. According to the Application, Petitioner sustained an injury to her left shoulder when an autistic student attacked her. This case was tried in a 19(b) proceeding and Petitioner sought an order for payment of medical bills as well as prospective medical treatment. Petitioner also filed a petition for penalties under Sections 19(k) and 19(l) and attorneys' fees under Section 16 of the Act.

Respondent stipulated that Petitioner sustained a work-related accident on April 1, 2011; however, Respondent disputed liability on the basis of causal relationship.

Petitioner worked for Respondent as a special education teacher. On April 1, 2011, Petitioner was assaulted by an autistic student who had significant behavior problems. In an effort to restrain the student, Petitioner applied what she described as a "basket" hold in which she held him close to her abdomen and immobilized his arms and hands. While Petitioner had the boy in this position, he repeatedly struck his head into Petitioner's left shoulder.

On April 5, 2011, Petitioner sought medical care from Dr. Kenneth Spicklemire, her family physician. At that time, Petitioner complained of left arm pain especially when she raised it or lifting anything. Dr. Spicklemire opined that Petitioner sustained a rotator cuff injury and prescribed medication. He ordered an MRI scan which was performed on May 18, 2011. The MRI revealed a superior labral tear extending into the biceps anchor. He referred Petitioner to Dr. Gary Ulrich, an orthopedic surgeon (Petitioner's Exhibit 1 and 3).

Dr. Ulrich examined Petitioner on May 31, 2011, and reviewed the MRI scan. He recommended Petitioner have arthroscopic surgery of the left shoulder. On June 22, 2011, Dr. Ulrich performed arthroscopic surgery which consisted of a superolabral anterior posterior repair (Petitioner's Exhibit 2).

Subsequent to the surgery, Petitioner remained under Dr. Ulrich's care and he ordered that she have physical therapy. Petitioner received physical therapy at Paris Community Hospital from June 24, 2011, through October 14, 2011 (Petitioner's Exhibit 4). Dr. Ulrich last saw Petitioner on November 6, 2011, and noted that Petitioner had done very well and had completed her physical therapy. On clinical examination, Petitioner had a full range of motion and a strength of 4/5. Petitioner still had complaints of pain, cramps, weakness, loss of strength and aches (Petitioner's Exhibit 1).

At trial, Petitioner testified that following her last visit with Dr. Ulrich on November 6, 2011, that she still continued to experience left shoulder symptoms, primarily pain in the front of the shoulder area extending across her chest and down to her hand. Petitioner's symptoms intensified during periods of cold weather. Petitioner stated that she did not seek medical treatment because it was her understanding that she would have some symptoms but that they would gradually improve. Petitioner experienced some improvement of her symptoms during the summer of 2012; however, her symptoms again intensified when the weather became colder.

Petitioner was seen by Dr. Spicklemire on December 12, 2012, and she complained of aching pain in the left shoulder that was exacerbated by the cold weather. Dr. Spicklemire prescribed medication and recommended Petitioner continue her rehabilitative exercises (Petitioner's Exhibit 1). At trial, Petitioner testified that Dr. Spicklemire referred her to Dr. Peter Sallay, an orthopedic surgeon, who specializes in shoulders.

At the direction of the Respondent, Petitioner was examined by Dr. Michael Nogalski, an orthopedic surgeon, on January 23, 2013. In connection with his examination, Dr. Nogalski reviewed medical records provided to him by Respondent. Dr. Nogalski described a normal clinical examination of Petitioner's left shoulder and noted that Petitioner had some mild complaints of left shoulder pain but that she was at MMI and no further medical treatment was indicated (Respondent's Exhibit 10).

Dr. Sallay examined Petitioner on April 29, 2013. At that time, Petitioner stated that the labral repair surgery never resolved her symptoms completely. Petitioner complained of left shoulder pain with numbness/tingling, the latter symptoms typically involving the middle and ring fingers but would, on occasion, involve the entire left hand. Dr. Sallay noted some residual rotator cuff weakness that was impairing shoulder function, but opined that her neural complaints appeared to be consistent with a carpal tunnel problem. He recommended Petitioner have physical therapy and that she be seen by Dr. Arthur Rettig, an orthopedic surgeon (Petitioner's Exhibit 5).

Dr. Rettig also saw Petitioner on April 29, 2013, and he ordered that Petitioner have an EMG performed (Petitioner's Exhibit 6). On May 29, 2013, Petitioner was seen by Dr. Philip Zaneteas, who performed and EMG/nerve conduction studies of the left upper extremity. The studies were within normal limits (Petitioner's Exhibit 7); however, Petitioner testified that before Dr. Zaneteas performed the test that he had to use a hair dryer to warm up her arm before proceeding with the test.

Dr. Rettig saw Petitioner on May 29, 2013, and he reviewed the EMG/nerve conduction studies with Petitioner and noted that they were essentially negative. In regard to Petitioner's neurogenic complaints, Dr. Rettig opined that Petitioner had complex regional pain syndrome. He prescribed Neurontin and ordered another MRI to rule out any underlying shoulder pathology (Petitioner's Exhibit 6).

Dr. Rettig saw Petitioner on June 17, 2013, and Petitioner advised that she had some improvement of her symptoms since beginning Neurontin. Dr. Rettig recommended that Petitioner continue to take Neurotin and he referred her to Dr. Anthony Sabatino, a pain specialist, for further evaluation of complex regional pain syndrome (Petitioner's Exhibit 6).

Petitioner was also seen by Dr. Sallay on June 17, 2013. At that time, Dr. Sallay opined that Petitioner had evidence of sympathetic dystrophy (Petitioner's Exhibit 5).

Dr. Rettig saw Petitioner on July 29, 2013, and Petitioner again advised that Neurontin relieved her symptoms but that without it, she had significant numbness and weakness. Dr. Rettig reaffirmed his recommendation that Petitioner be seen by a pain management specialist and that

she may benefit from a stellate ganglion block. In regard to causality, Dr. Rettig stated in his record: "I feel this is related to her workman's comp case as it is a rather uncommon sequelae from this injury and surgery." (Petitioner's Exhibit 6).

Petitioner testified that she did not see Dr. Rettig or any other medical providers for treatment after July 29, 2013, because neither workers' compensation nor her group health carrier would pay for her treatment. Petitioner's supply of Neurontin ran out sometime in October, 2013, but she was able to secure another prescription for in January, 2014.

Again, at the direction of Respondent, Dr. Nogalski examined Petitioner on October 2, 2013. In connection with his examination, Dr. Nogalski reviewed medical records provided to him by Respondent. Dr. Nogalski's findings on clinical examination were positive for mild/moderate carpal tunnel syndrome, cubital tunnel syndrome and possible mild cervical radiculopathy; however, he opined that none of these conditions were indicative of regional pain syndrome nor were they related to the shoulder injury. He opined Petitioner was at MMI in regard to her shoulder injury. He agreed that further medical treatment might be indicated but it would be for non-work-related conditions. He stated that a stellate ganglion block could be considered a last measure to evaluate her for a non-work-related complaint (Respondent's Exhibit 11).

Dr. Rettig was deposed on November 12, 2013, and his deposition testimony was received into evidence at trial. Dr. Rettig's testimony was consistent with his medical records and he reaffirmed his opinion that Petitioner had complex regional pain syndrome which he causally related to the surgery Petitioner underwent following the accident. He also testified that Petitioner's continued use of Neurontin and a stellate ganglion block procedure were reasonable and necessary medical treatment (Petitioner's Exhibit 8; pp 6-11). Dr. Rettig did agree that Petitioner's symptoms were not a classic presentation of complex regional pain syndrome, but that there were different degrees of this condition some of which exhibited classical symptoms and others which did not (Petitioner's Exhibit 8; pp 16-20).

Dr. Nogalski was deposed on March 3, 2014, and his deposition testimony was received into evidence at trial. Dr. Nogalski's testimony was consistent with his medical reports and he reaffirmed his opinions that Petitioner did not have complex regional pain syndrome, the left upper extremity condition/symptoms were not causally related to the accident and that, in regard to the left shoulder injury, Petitioner was at MMI. On cross-examination, Dr. Nogalski agreed that if Neurontin helped relieve symptoms, it was usually because the patient had a nerve problem and that if a stellate ganglion block worked that it would be supportive of the diagnosis of complex regional pain syndrome (Respondent's Exhibit 17; pp 15-16, 22).

Various medical bills/receipts were tendered into evidence at trial and Petitioner sought either payment or reimbursement of same (Petitioner's Exhibits 8, 9 and 10). Petitioner testified that her left shoulder pain has become more intense since she stopped taking Neurontin in October, 2013. Fortunately, because she was able to secure another prescription for Neurontin in January, 2014, she has experienced some improvement of her shoulder symptoms. Petitioner does want to proceed with the stellate ganglion block as recommended by Dr. Reddick.

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 April 1, 2011.

In support of this conclusion the Arbitrator notes the following:

There was no dispute that Petitioner sustained a work-related injury to her left shoulder on April 1, 2011, when it was struck multiple times by the head of an autistic student who Petitioner was attempting to restrain.

There was no evidence that Petitioner sustained any injury or had any left shoulder symptoms prior to April 1, 2011.

Petitioner was a credible witness on her own behalf.

The Arbitrator finds the opinion of Petitioner's primary treating physician, Dr. Rettig, to be more credible and persuasive than the opinion of Respondent's Section 12 examiner, Dr. Nogalski. Dr. Rettig opined that Petitioner has complex regional pain syndrome which he attributed to the labral surgery that Petitioner had on her left shoulder. While Dr. Nogalski opined that Petitioner does not have complex regional pain syndrome, he found a number of other conditions referable to the left upper extremity. He also noted that a positive response to Neurontin was indicative of a nerve problem and that a stellate ganglion block could be supportive of the diagnosis of complex regional pain syndrome.

In regard to disputed issue (J) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes that all of the medical treatment provided to Petitioner was reasonable and necessary and that Respondent is liable for payment/reimbursement of the medical bills incurred therewith.

Respondent shall pay/reimburse reasonable and necessary medical services as identified in Petitioner's Exhibits 8, 9 and 10, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule.

In regard to disputed issue (K) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes that Petitioner is entitled to prospective medical treatment, including, but not limited to, ongoing prescriptions for Neurontin and a stellate ganglion block as recommended by Dr. Rettig.

In regard to disputed issue (M) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes that Petitioner is not entitled to Section 19(k) and 19(l) penalties and Section 16 attorneys' fees.

In support of this conclusion the Arbitrator notes the following:

Respondent's reliance on the opinions of Dr. Nogalski in denying liability in this case was reasonable and was not in bad faith.

William R. Gallagher, Arbitrator