STATE OF ILLINOIS)
) SS.
COUNTY OF)
CHAMPAIGN

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Andrew Smith,
Petitioner,

vs. NO: 11 WC 24617

National Freight,
Respondent.

17IWCC0001

DECISION AND OPINION ON REVIEW

Timely Petition for Review under Section 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, medical expenses, prospective medical expenses, application of Law of the case doctrine 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 hereby 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 November 5, 2015 is hereby affirmed and adopted.

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

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

IT IS FURTHER ORDERED BY THE COMMISSION 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.

17IWCC0001

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 6 - 2017

Joshua D. Luskin

Charles J. DeVriendt

o-12/06/16
jdl/wj
68

DISSENT

I respectfully dissent from the Decision of the majority. I would have found that Petitioner did not sustain his burden of proving that his current condition of ill-being was caused by the accident on May 25, 2011, reversed the Decision of the Arbitrator, and denied compensation.

Petitioner was employed as a truck driver and sustained two separate work related motor vehicle accidents while working for this employer; one on December 8, 2008, and the instant accident on May 25, 2011. The initial claim was adjudicated in Petitioner's favor and he was awarded temporary total disability benefits and ordered prospective surgery. In January of 2010, Dr. Kennedy performed fusion at L3-4 and L4-5. That claim was eventually settled on September 29, 2014 for $153,210.26 and in the settlement Petitioner waived his rights for future medical under Section 8(a) and for worsened condition under Section 19(h).

The instant claim was arbitrated in a previous proceeding pursuant to Section 19(b) on August 14, 2012. The previous Arbitrator found Petitioner condition of ill-being was caused by the May 25, 2011 and awarded benefits including prospective surgery recommended by Dr. Kennedy which was removal of the previous instrumentation, decompression at L2-3, and re-instrumentation at L2-5. Thereafter, Petitioner continued to see Dr. Kennedy periodically, but did not undergo the surgery. On August 6, 2013, Dr. Kennedy diagnosed severe spinal stenosis and instability at L2-3 adjacent to the previous fusion at L3-4 and L4-5. He attributed the need for surgery at L2-3 to the previous fusion surgery necessitated by the work injury of December 8, 2008. Respondent's Section 12 medical examiner, Dr. Lange also opined that the current need for surgery was related to adjacent disc syndrome related to surgery associated with the December 8, 2008 accident. Dr. Kennedy did not mention the May 25, 2011 accident causing the need for prospective surgery until March 23, 2015.

In the instant Section 19(b) proceeding, the current Arbitrator considered himself bound by the opinion of the previous Arbitrator under the doctrine of the "law of the case." I do not believe that the law of the case doctrine applies here. Initially, Respondent is correct that the Commission must consider each 19(b) proceeding on its own merit. *See, Weyer v. I.W.C.C.* 387 Ill. App. 3d 297 (1st Dist. 2008). In any event, the law of the case doctrine would apply only to a particular condition of ill-being. In this instance the condition of ill-being does not appear to be identical because the recommended intervention is different.

Based on the record before us, I would have found that Petitioner did not sustain his burden of proving a causal connection between his work accident on May 25, 2011, reversed the Decision of the Arbitrator, and denied compensation. For the reasons outlined above, I respectfully dissent.

Ruth W. White

Ruth W. White

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

SMITH, ANDREW
Employee/Petitioner

Case# **11WC024617**

NATIONAL FREIGHT
Employer/Respondent

17IWCC0001

On 11/5/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.28% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4463 GALANTI LAW OFFICES
LESLIE N COLLINS
PO BOX 99
EAST ALTON, IL 62024

0481 MACIOROWSKI SACKMANN & ULRICH
ROBERT E MACIOROWSKI
105 W ADAMS ST SUITE 2200
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF CHAMPAIGN)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Andrew Smith
Employee/Petitioner

Case # 11 WC 24617

v.

Consolidated cases: n/a

National Freight
Employer/Respondent

17IWCC0001

An *Application for Adjustment 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 September 11, 2015. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, May 25, 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 $53,220.96; the average weekly wage was $1,023.48.

On the date of accident, Petitioner was 45 years of age, married with 0 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 $1,364.64 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $1,364.64.

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

ORDER

Respondent shall pay reasonable and necessary medical services in the amount of $4,902.03 as identified in Petitioner's Exhibit 7 for medical services provided to Petitioner as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule.

Respondent shall pay Petitioner prospective medical treatment including, but not limited to, the surgery recommended by Dr. Kennedy.

Respondent shall pay Petitioner temporary total disability benefits of $682.32 per week for 160 2/7 weeks commencing August 14, 2012, through September 11, 2015, as provided in Section 8(a) of the Act.

Petitioner's Petition for penalties and 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)

November 4, 2015
Date

NOV 5 - 2015

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged he sustained an accidental injury arising out of and in the course of his employment for Respondent on May 25, 2011. According to the Application, Petitioner sustained an injury to the man as a whole when a truck was blown over by a 60 mile per hour wind (Arbitrator's Exhibit 2).

This case was tried in a 19(b) proceeding and Petitioner sought an order for payment of temporary total disability benefits and medical bills. Petitioner also filed a Petition for Section 19 (k) and 19(l) penalties as well as Section 16 Attorneys' Fees. Respondent disputed liability on the basis of causal relationship (Arbitrator's Exhibit 1). Petitioner's entitlement to prospective medical treatment was not specifically indicated on the Request for Hearing as a disputed issue; however, given the procedural history of this case as discussed herein, Petitioner was apparently seeking an order for this as well.

This case was previously tried in a 19(b) proceeding before Arbitrator Douglas McCarthy on August 14, 2012. At that time, Petitioner sought an order for payment of temporary total disability benefits and medical bills as well as prospective medical treatment. Respondent disputed liability on the basis of accident and causal relationship. Arbitrator McCarthy's Decision was filed with the Commission on October 1, 2012, and he ruled in favor of Petitioner and ordered Respondent to pay temporary total disability benefits from June 15, 2011, through August 14, 2012, and medical bills. He also ordered Respondent to "...pay the prospective medical as proposed by Dr. Kennedy." (Arbitrator's Exhibit 4; p 3).

In regard to Dr. Kennedy's surgical recommendation, Arbitrator McCarthy noted in his findings of fact that Dr. Kennedy recommended Petitioner have his prior instrumentation removed, have a decompression at L2-L3 and be re-instrumented from L2 to L5 (Arbitrator's Exhibit 4; p 6). The prior instrumentation was from a back surgery that Dr. Kennedy previously performed at L3-L4 and L4-L5.

Respondent filed a review of Arbitrator McCarthy's Decision with the Commission. In a Decision and Opinion on Review filed on April 26, 2013, the Commission affirmed and adopted Arbitrator McCarthy's Decision (Petitioner's Exhibit 5).

Respondent subsequently appealed the Decision of the Commission to the Circuit Court of Montgomery County and then to the Appellate Court. When this case was before the Appellate Court, Respondent argued that the Commission's determination that Petitioner's condition of ill-being and need for surgery was contrary to the law and manifest weight of the evidence. Specifically, Respondent argued that Petitioner's back condition was, in fact, related to a prior work-related injury that occurred in December, 2008. The Appellate Court ruled against Respondent and found that the Commission's Decision was not against the manifest weight of the evidence and affirmed and remanded same (Petitioner's Exhibit 6).

In its review of the record, the Appellate Court noted the conflicting opinions regarding causality of Petitioner's treating physician, Dr. David Kennedy, and employer's examiner, Dr. David Lange, and noted that the Commission had found the opinion of Dr. Kennedy to be more persuasive. The

Appellate Court noted that the employer was requesting that the Court "... reweigh the evidence presented, which is not the appropriate function of this court on review." (Petitioner's Exhibit 6; p 13).

In the current 19(b) proceeding, Petitioner testified that he was employed as a truck driver by Respondent and that, on May 25, 2011, a tornado picked up the truck he was driving and threw at approximately 116 feet. Petitioner has been treating with Dr. Kennedy since shortly after the accident and Dr. Kennedy has authorized him to remain off work. In regard to the surgery recommended by Dr. Kennedy, Petitioner agreed that this procedure was delayed because of some heart issues that he had.

At trial, Petitioner introduced into evidence Dr. Kennedy's records/notes for treatment and office visits provided by him to Petitioner from October 29, 2012, through May 21, 2015. This record also included an office note dated September 8, 2015, but the admission of this particular office note was objected to by Respondent's counsel and said objection was sustained by the Arbitrator. In these various office notes, Dr. Kennedy continued to authorize the Petitioner to remain off work pending surgery. Several of the office notes made reference to the date of accident as being 11/6/06; however, the office notes dated March 25, 2015, and May 21, 2015, reference the date of accident as being 5/25/11 (Petitioner's Exhibit 2).

In Dr. Kennedy's office note dated August 6, 2013, Dr. Kennedy stated: "I attribute his need for surgical intervention to the prior fusion which is a result of the work related injury on December 3, 2008." (Petitioner's Exhibit 2; p 23) (Respondent's Exhibit 4). In that same report, Dr. Kennedy's surgical recommendation was that Petitioner undergo a lumbar decompression and fusion at L2-L3. Dr. Kennedy did not make any reference to either removal of old instrumentation or re-implanting new instrumentation as he had previously.

The evidence depositions of Dr. Kennedy and Dr. Lange taken on April 10, 2012, and April 17, 2012, respectively, were received into evidence at trial. These depositions were also tendered into evidence at the time of the prior 19(b) hearing before Arbitrator McCarthy. As was noted in Arbitrator McCarthy's Decision, and affirmed by the Commission, Circuit Court, and Appellate Court, Dr. Kennedy's opinion that there was a causal relationship between Petitioner's condition of ill-being and the accident of May 25, 2011, was found to be more persuasive than that of Dr. Lange who opined that there was not such a causal relationship.

Petitioner's position was that Respondent's disputing causal relationship between the accident of May 25, 2011, and Petitioner's current condition of ill-being was not one that can be raised by Respondent at this time because this issue was previously adjudicated by the Appellate Court. Specifically, Petitioner argues that the Court's determination is the "law of the case" and cites Irizarry v. Industrial Commission, 786 N.E. 2d 218 (Ill. App. 2nd Dist. 2003), as authority.

Respondent's position was that the second 19(b) proceeding involved different legal and factual issues than the first 19(b) proceeding. Because of the preceding, Respondent asserts that the prior finding of a causal relationship is not binding in this proceeding as a result of the "law of the case" doctrine. Respondent cited Weyer v. Illinois Workers' Compensation Commission, 900 N.E. 2d 360 (Ill. App. 1st Dist. 2008), as authority.

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 May 25, 2011.

In support of this conclusion the Arbitrator notes the following:

The Arbitrator concludes that this issue was previously adjudicated and is the "law of the case" and cannot be retried in this proceeding.

In the Irizarry case, the case was initially tried in a 19(b) proceeding in which the Petitioner alleged injuries to multiple body parts including his left knee. The Arbitrator awarded Petitioner benefits and found that he had sustained injuries to the left knee, neck, right shoulder and lower back. Neither side took a review and it became final. In a subsequent 19(b) proceeding, another Arbitrator found that there was no causal relationship between Petitioner's head, neck, low back and right shoulder. The Arbitrator's Decision in the second 19(b) proceeding was confirmed by the Commission but reversed by the Appellate Court. The Court found that once the Arbitrator's Decision in regard to the first 19(b) proceeding became final, that Decision became the "law of the case" and could not be revisited with the singular exception of the head injury because the first Decision did not make a finding of causal relationship for that part of the anatomy. Irizarry at 224-225.

In the Weyer case, there was a 19(b) proceeding in which the Arbitrator determined that Petitioner's left shoulder injury was causally related to the work-related accident and awarded temporary total disability benefits and medical. In a subsequent 19(b) Decision, the same Arbitrator found that Petitioner failed to prove that his left shoulder condition, as it existed at the time of the second 19(b) proceeding. The Court held that the Arbitrator's first Decision was not binding and that the "law of the case" doctrine did not apply. However, there was a significant difference in the pathology of the left shoulder between the time of the first and second 19(b) proceedings. Specifically, at the time of the second 19(b) proceeding, Petitioner was diagnosed with a SLAP lesion which was not diagnosed prior to the first 19(b) proceeding and was diagnosed approximately two years post accident. Weyer at 369.

In the instant case, there has been no change in the pathology regarding Petitioner's low back. Dr. Kennedy has consistently recommended Petitioner undergo back surgery. The Arbitrator notes that in Arbitrator McCarthy's 19(b) Decision, Dr. Kennedy recommended that Petitioner have prior instrumentation removed, a decompression at L2-L3, and new instrumentation at L2 to L5. His more recent surgical recommendation is different, namely, that Petitioner have a lumbar decompression and fusion at L2-L3.

The Arbitrator does not view Dr. Kennedy's modified surgical recommendation to be analogous with the separate shoulder pathology as was diagnosed in the Weyer case.

The Arbitrator does note that Dr. Kennedy made a statement in one medical record that attributed the need for surgery to the accident of December 3, 2008, and a number of other notes that referenced the date of accident as being 11/6/2006. The preceding appears to be erroneous as it was contrary to what Dr. Kennedy testified to as well as Arbitrator McCarthy's prior 19(b) Decision. In spite of what appears to be a contradiction, the Arbitrator cannot find a basis to overrule the "law of the case" doctrine as it applies to this case.

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

The Arbitrator concludes that Respondent is liable for all of the medical bills for services rendered to Petitioner and that Respondent is liable for payment of the medical bills incurred therewith.

Respondent shall pay reasonable and necessary medical services of $4,902.03 as identified in Petitioner's Exhibit 7, 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 Petitioner is entitled to prospective medical treatment including, but not limited to, the surgery recommended by Dr. Kennedy.

In regard to disputed issue (L) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes Petitioner is entitled to payment of temporary total disability benefits of 160 2/7 weeks commencing August 14, 2012, through September 11, 2015.

In regard to disputed issue (M) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes Petitioner is not entitled to Section 19(k) and Section 19(l) penalties or Section 16 Attorneys' Fees.

In support of this conclusion the Arbitrator notes the following:

Even though the Arbitrator has ruled that the "law of the case" doctrine is applicable and that Petitioner's current condition of ill-being is causally related to the accident of May 25, 2011, the Arbitrator does not find Respondent's actions to be either vexatious or in bad faith.

The holding in the Weyer case provided a basis for Respondent to assert that the law of the case doctrine was not applicable. Further, Dr. Kennedy's medical record of August, 2013, purported to relate Petitioner's current condition to a prior accident which, as noted herein, was inconsistent with his prior testimony.

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF)
WILLIAMSON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

WILBUR WILLIAMS,

Petitioner,

vs.

NO: 15 WC 5322
15 WC 5323

RADIAC ABRASIVES,

Respondent,

17IWCC0002

DECISION AND OPINION ON REVIEW

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

The Commission finds that Petitioner's current low back condition remains causally related to his first accident on December 3, 2013, and that the second accident, on December 17, 2014, was a flare-up of that condition. We note that Respondent stipulated that Petitioner sustained accidental injuries on both of these dates but disputed causal connection with his current condition.

Petitioner was able to perform his job full duty grinding wheels as a machine operator prior to his first injury on December 3, 2013. He was initially diagnosed with a lumbar strain but, following an MRI, Dr. Kovalsky diagnosed a small, symptomatic annular tear at L5-S1 with mechanical back pain. Dr. Kovalsky did not recommend surgery but for the next ten months Petitioner was treated with multiple courses of physical therapy, epidural steroid injections, and worked sedentary/light duty. The records show that Petitioner continued to improve and on October 2, 2014, Dr. Kovalsky noted that Petitioner had no pain at that time, although he did have 1-out-of-10 pain during the past week. Dr. Kovalsky noted that Petitioner was able to lift 50 pounds in therapy and returned Petitioner to full duty as of October 6, 2014.

Petitioner testified that he returned to work performing the same task that he had been

performing prior to his injury and that he was a little sore but did not have any trouble with his back "right off the bat." He testified that he began having increased soreness in the beginning of December. Petitioner testified that the longer he stood and cranked on the grinding machine, it caused increased stress on his neck, mid back, and low back, and that his back "started getting tighter and hurt more." He reported this increased back pain to Respondent on December 18th. The records show that he continued working for a few weeks until he saw Ms. Branch, APRN-CNP on January 6, 2015, and complained of gradual onset of worsening low back pain related to twisting and lifting. He was diagnosed with a low back strain and was prescribed medications, light duty, and referred to an orthopedic physician.

On February 13, 2015, Petitioner began treating with Dr. Raskas who recorded a history of Petitioner's December 2013 work injury and treatment. Dr. Raskas noted that Petitioner "went to work back out on the floor and after 2 months tells me his low back pain was unbearable again." The Commission notes that this history is consistent with Petitioner's testimony. Dr. Raskas ordered sedentary restrictions and a repeat MRI, which was performed on February 27, 2015. On March 13th, Dr. Raskas noted that the MRI was fairly unremarkable except for the small annular tear at L5-S1 and opined that "[i]n all likelihood the back pain is coming from the annular tear." The Commission finds that this annular tear is at the same level that was found after Petitioner sustained his December 13, 2013 accident. Dr. Raskas noted that Petitioner wanted to avoid surgery "if at all possible" and prescribed Naprosyn and a functional capacity evaluation. This was performed on April 3, 2015, and showed that Petitioner gave good effort during the evaluation. On April 17, 2015, Dr. Raskas interpreted the results as showing that Petitioner could only perform at the medium physical demand level. Dr. Raskas opined that Petitioner was not functioning well enough with standing, bending, or reaching to perform his regular duty job and also had lifting limitations. He recommended work restrictions versus having surgery, and found Petitioner to be at maximum medical improvement "should things not worsen."

On May 11, 2015, Petitioner was examined by Respondent's Section 12 examiner, Dr. Stiehl, who recorded a history of Petitioner's December 2013 work injury, treatment, and subsequent return to work. He wrote, "However, on or about December 18, 2014, he had a new claim of injury and now is bothered with the same level of chronic back pain as he had before." Dr. Stiehl reported that he reviewed Petitioner's MRI and he did not find any significant problems. However, he did diagnose Petitioner with continued lower back pain that "flared" after December 18, 2014. Interestingly, Dr. Stiehl opined that Petitioner had not reached maximum medical improvement and should undergo 6 to 8 weeks of therapy and work conditioning. He believed that Petitioner could eventually return to full duty but he was "not certain" until Petitioner completed work hardening. On the issue of causation, Dr. Stiehl wrote, "It is difficult to know exactly the recent causation, as the medical records are not available for review. Based on the available information, I believe he may have experienced an aggravation of his age-related degenerative arthritis as a result of his return to work."

We note that Petitioner had also been examined by Dr. Stiehl on July 7, 2014, in relation to the first accident. In that report, one of Dr. Stiehl's conclusions was, "There are no obvious pre-existing conditions, but I did find a history that he had been treated for some back complaints with physical therapy a couple of years ago." It is not entirely clear what records Dr. Stiehl might be referring to but the "Medical Records Review" section in his report seems to indicate that his source was a January 9, 2014, note from Mary Piper at St. Mary's Family Health Center because it is in this paragraph that Dr. Stiehl wrote that Petitioner "treated with some minor

17IWCC0002

physical therapy a couple of years ago." However, the records from January 9, 2014 do not support this finding and actually explicitly state "no past medical history on file." Petitioner testified that he never had any low back injuries or treatment prior to his first accident with Respondent. However, on cross-examination, he admitted that he did have a muscle spasm 30 years ago and he was put on a table "that stretches you" at the hospital. Regardless, even if there were records to show that Petitioner underwent some minor physical therapy a couple of years prior, we find that the evidence shows that Petitioner did not have chronic back pain prior to his first accident at Respondent.

The Commission finds that the December 17, 2014 accident, which was stipulated to by Respondent, cannot be viewed in a vacuum. Rather, it should be seen on a continuum and considered in light of Petitioner's previous injury. We find that Petitioner was diagnosed with a symptomatic L5-S1 annular tear after his first accident. Although he was eventually returned to work full duty, he began to have increasing pain while performing his job. We find that his continued full duty work caused a "flare" of his pre-existing condition, which was the annular tear that was sustained in the first accident. We note that Petitioner had not undergone a functional capacity evaluation prior to being released after his first accident. Although no new recommendations for surgery or treatment were recommended after the second "accident" (other than by Respondent's own Dr. Stiehl for more work conditioning), he now has permanent restrictions prescribed by Dr. Raskas based on a valid functional capacity evaluation. It was only after Petitioner attempted to return to work full duty for a couple of months that it became apparent that his low back condition was still causing him problems. We find that these continued problems remain causally related to the L5-S1 annular tear sustained in the first accident.

Based on the above finding of causal connection, we hereby award Petitioner medical expenses of $32,345.84 under §8(a) of the Act, subject to the fee schedule in §8.2 of the Act. This includes those expenses incurred after December 17, 2014, which were denied by the Arbitrator. Respondent shall be entitled to §8(j) credit for payments made by its group insurance carrier; provided that Respondent shall hold Petitioner harmless from any claims and demands by any providers of the benefits for which Respondent is receiving credit.

Petitioner requests a permanent partial disability award for "disabling symptomatic disc pathology at L3-4, L4-5, and L5-S1, consisting of bulging disks and/or annular tearing." (Petitioner's brief at 15). However, although there is some mention of those levels in the MRIs, there is no medical opinion to support symptomatic disc pathologies at L3-4 and L4-5. The only injury identified by Dr. Kovalsky and Dr. Raskas attributable to Petitioner's symptoms was a small annular tear at L5-S1. Respondent's Dr. Stiehl found that Petitioner "may have experienced an aggravation of his age-related degenerative arthritis as a result of his return to work" but did not identify anything specific structurally.

We find that Petitioner sustained an L5-S1 annular tear as a result of the December 3, 2013 accident and that his condition remains causally related to that accident. The parties stipulated that Petitioner's average weekly wage was $654.11 at the time of that accident and that is the wage on which we are awarding permanency benefits. Based on the five factors in §8.1b(b), we find that no impairment rating was introduced by either party so that is given no weight. Regarding his occupation as a machine operator, Respondent is accommodating his restrictions so far but Petitioner testified that if he needs help on the "harder wheels" he tells the supervisor and receives assistance. We give this factor some weight. We find that at 62 years of age at the time of injury, Petitioner has less anticipated work years ahead of him than a younger

17IWCC0002

worker and give this less weight. There is no evidence of future earning capacity and Petitioner continues to work for Respondent within his restrictions. However, Petitioner's injuries caused permanent restrictions that would prevent him from obtaining future employment in his previous occupation with a different employer. This factor is given some weight. Regarding evidence of disability corroborate by the treating medical records, we find that Petitioner sustained an L5-S1 annular tear, for which he treated conservatively with no surgery. He has permanent restrictions and needs assistance at work when dealing with parts that are too heavy. The Commission places great weight on this factor. Based on the above, we find that Petitioner has sustained the loss of use of 12.5% of the person as a whole under §8(d)2.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $392.47 per week for a period of 62.5 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the loss of use of 12.5% of the person as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $32,345.84 for medical expenses under §8(a) of the Act, subject to the fee schedule in §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is entitled to a credit under §8(j) of the Act for payments made by its group insurance carrier; provided that Respondent shall hold Petitioner harmless from any claims and demands by any providers of the benefits for which Respondent is receiving credit under this order.

IT IS FURTHER ORDERED BY THE COMMISSION that 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 $39,100.00. 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 11 2017

Charles J. DeVriendt

Ruth W. White

Joshua D. Luskin

SE/
O: 12/7/16
49

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WILLIAMS, WILBUR
Employee/Petitioner

Case# **15WC005322**

15WC005323

RADIAC ABRASIVES
Employer/Respondent

17IWCC0002

On 10/2/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.10% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

2795 HENNESSY & ROACH PC
KATHERINE M WHITAKER
415 N 10TH ST SUITE 200
ST LOUIS, MO 63101

17IWCC0002

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

Wilbur Williams
Employee/Petitioner

v.

Radiac Abrasives
Employer/Respondent

Case # 15 WC 05322

Consolidated cases: 15 WC 05323

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Herrin**, on **August 12, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **December 3, 2013, and December 17, 2014,** 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 December 3, 2013, Petitioner ***did*** sustain an accident that arose out of and in the course of employment.
On December 17, 2014, Petitioner ***did*** sustain an accident that arose out of and in the course of employment.

Timely notice of these accidents ***was*** given to Respondent.

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

In the year preceding the **December 3, 2013** injury, Petitioner earned **$30,013.73**; the average weekly wage was **$654.11**.

In the year preceding the **December 17, 2014** injury, Petitioner earned **$34,569.78**; the average weekly wage was **$664.80**.

On **December 3, 2013**, Petitioner was **62** years of age, ***married*** with **2** dependent child(ren).

On **December 17, 2014**, Petitioner was **63** years of age, ***married*** with **2** dependent child(ren).

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

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

ORDER

Respondent has paid reasonable and necessary medical services as provided in § 8(a) of the Act.

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

Respondent shall pay Petitioner permanent partial disability benefits of $392.47/week for 30 weeks, because the injuries sustained on December 3, 2013 caused the 6% loss of the body as a whole, as provided in § 8(d)2 of the Act.

Petitioner is not entitled to an award for permanent partial disability benefits with respect to the alleged date of accident December 17, 2014.

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

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

9/21/15
Date

OCT 2 - 2015

Wilbur Williams v. Radiac Abrasives
Case # 15 WC 05322
15 WC 05323

After reviewing all of the evidence presented, the Arbitrator hereby makes the following findings of fact and conclusions of law regarding the issues in the above-entitled cause:

FACTS:

Petitioner is a 63 year old male. (T.25). He has six children, and eight grandchildren. Currently, three children and three grandchildren live with Petitioner and his wife. (T.26).

Petitioner testified he has had no prior workers' compensation claims to his low back and has no injuries to his low back whatsoever. (T.9-10). He denied every having physical therapy for a back condition prior to December of 2013. (T. 27). On the date of the first accident, December 3, 2013, he was boring a hole out on a grinding wheel. The wheel was specifically an epoxy wheel, which is slick and it had started to come out. When Petitioner stretched around the machine to shut it off, it felt like someone had stabbed him. (T.11). He reported the injury to the supervisor. (T.11).

Petitioner saw his primary care physician, Dr. Mary Piper, who referred him to Dr. Kovalsky. (T.32).

Petitioner missed approximately a week of work for which he was compensated by Respondent's workers' compensation insurer. (T.12). After that week, he went back to work on light duty for 10 months. (T.12-13). In October, Petitioner was advised by his doctor that he could return to work full duty and he resumed working on a machine which was similar to the machine he was running when the alleged accident happened. (T. 13-14). When he returned to full duty on October 6, 2014, his back was a little sore but he did not have any trouble with it. (T. 29). He ran this machine from October to December 17, 2014 but stated the longer he stood behind the machine, the worse his back would hurt. (T.15).

Petitioner denied any specific accident happened on December 17, 2014. (T. 29). He testified he noticed his back getting sore the first week in December after he had worked full duty approximately two months. (T. 29). Petitioner was then sent to Dr. Raskas by his attorney. (T. 32). He testified Dr. Raskas did not offer any treatment. (T. 32-33). He did not see Dr. Raskas until February of 2015. (T.18). Dr. Raskas placed him on light duty which the employer continues to accommodate. (T. 18).

Petitioner saw Dr. James Stiehl on July 7, 2014 and May 11, 2015. (T.16). Dr. Stiehl recommended he go back to therapy to strengthen his back but he never did because nobody ever scheduled him for therapy. (T. 30). Petitioner admitted he never requested physical therapy. (T. 30). After the first date of injury, Petitioner went through

three different rounds of physical therapy and testified the third time helped his back pain. (T. 31).

As of the date of trial, Petitioner was working light duty. (T. 17). Petitioner is currently running a reamer, which bores holes into small wheels. (T. 19). He is capable of doing most of this job. (T. 19). Petitioner can pull approximately 7 pounds (T. 19). Petitioner denies any accidents or injuries after December of 2013. (T. 21). He testified the restrictions that Dr. Raskas placed on him, and the restrictions from the functional capacity evaluation were permanent in nature. (T. 21).

Petitioner testified his back hurts right above the belt line when he sits or stands too long. He also indicated his bending is not very good. The pain occasional goes down into the buttocks, but not into the legs. (T. 22-23). He was taking medication for pain, but stopped taking it because it was not working. (T. 28).

When asked about hobbies, Petitioner testified he has a big bass boat and cannot unload or load it by himself. (T. 23-24). He also has not tried playing golf or throw horseshoes since his injury. (T. 24). Petitioner also stated he has trouble playing with his grandchildren. (T. 33).

MEDICAL:

According to the notes from Dr. Mary Piper, Petitioner's primary care physician, Petitioner went to the emergency room on December 3, 2013 and the X-rays taken there were negative. Dr. Piper, from St. Mary's Good Samaritan saw Petitioner on December 5, 2013 and noted he sustained a lumber strain/sprain. The doctor administered a Ketorolac injection and prescribed Medrol Dosepak and Flexeril. (P.Ex.3, 12/5/13).

Petitioner returned to Dr. Piper on January 2, 2014. He reported increased pain after lifting more Monday night and Tuesday night. At that time he reported increased pain after lifting more at work. Petitioner was placed on work restrictions of not lifting more than 10 pounds and no bending or twisting and prescribed physical therapy. (P.Ex.3, 1/2/14)

On February 6, 2014, Dr. Piper noted Petitioner was having a slight benefit with therapy but still continued to work light duty. Petitioner reported on March 5, 2014 his pain was at a 3 out of 10 at rest and a 5 out of 10 with light activity. (P.Ex3, 2/6/14). By March 7, 2014, Petitioner was doing better with some pain with bending forward or squatting. The MRI taken on March 7, 2014 revealed multilevel degenerative changes with mild disc bulges at L4-5 and bilaterally at L3-4 but slightly worse on the left than the right. Some degree of far lateral nerve root impingement was not excluded. (P.Ex.5).

Dr. Kovalsky evaluated Petitioner on April 4, 2014. The doctor observed Petitioner walked with a limp but stated the limp was due to Petitioner's knee pain. In his opinion, the MRI showed a small annular tear at L5-S1 with a small contained central

disc herniation of 2 to 3 mm not causing significant neural compression. The MRI also showed facet generation at L3 to the sacrum without severe foraminal narrowing or spinal stenosis. Dr. Kovalsky referred him to Dr. Froehling and allowed him to continue on light duty. Petitioner was then referred to Dr. Smith for bilateral transforminal epidural steroid injections at L5-S1. Petitioner was also advised to continue physical therapy once his knee problems resolved. He was put on Prednisone and Flexeril. He continued with Tramadol and Naprosyn. Dr. Kovalsky noted the findings were relatively mild and not amendable to surgery. (P.Ex.4).

Bilateral epidural injections were performed on April 22, 2014, May 6, 2014 and June 2, 2014 by Dr. Aiping Smith. (P.Ex.4).

Dr. James Stiehl performed an independent medical examination of Petitioner on July 7, 2014. At that time, Petitioner had approximately 8 weeks of physical therapy but still had chronic stiffness. His diagnosis was low back strain. Dr. Stiehl did note he found a history that Petitioner had been treated for some back complaints with physical therapy a couple of years ago. Dr. Stiehl found no symptoms consistent with radiculopathy in either extremity. He stated "He simply has a stiff, painful back." and "The MRI scan for his age is considered benign." In his opinion, Petitioner was not capable of full duty at that time and he recommended 4-6 weeks of physical therapy. Dr. Stiehl related the lumbar strain to the December 3, 2013 work injury. He anticipated Petitioner would be at maximum medical improvement within the next six weeks or so. (R.Ex.A).

On September 4, 2014, Dr. Kovalsky opined that Petitioner had preexisting degenerative disc disease with exacerbation and lumbosacral strain. He was progressing well with physical therapy and the lifting restriction was increased to 30 pounds. (P.Ex.4).

The medical records from Dr. Kovalsky dated October 31, 2014 stated Petitioner had returned to work full duty on October 6, 2014 and had no complaints of back or leg pain. His impression was lumbosacral strain and resolved mechanical back pain. (P.Ex.4).

On February 13, 2015, Petitioner saw Dr. Raskas at the direction of his attorney. Petitioner had complaints of low back pain and muscle spasms. Petitioner told Dr. Raskas he was injured at work in December of 2013. After two months of full duty beginning in October 2014, his back began hurting again. This medical record indicated Petitioner is not working even though the employer has light duty available. Dr. Raskas reviewed lumbar spine films which did not demonstrate any evidence of fracture or tumor and showed age appropriate degenerative changes. The MRI was about a year old and showed some mall disc bulge at the L5-S1 segment. Dr. Raskas recommended a repeat MRI. (P.Ex.7).

Dr. Raskas reviewed the new MRI on March 13, 2015. He noted the MRI was fairly unremarkable with the exception of mild age appropriate degenerative

changes. There was a small annular tear present at L5-S1 and a small amount of foramina stenosis present at L4-5. Petitioner did not have symptoms consistent with nerve compression. The back pain is likely coming from the annular tear. Dr. Raskas discussed permanent restrictions in lieu of surgery. Petitioner was not interested in surgery. He recommended a functional capacity evaluation. (P.Ex.7).

On April 17, 2015, Petitioner returned to Dr. Raskas after the FCE. The results of the FCE showed he is functioning at the medium demand level. Dr. Raskas recommended work restrictions of a pushing limit of 39 pounds, pulling limit of 7 pounds occasionally, floor to waist lift not at all, waist to shoulder lift 15 pounds and shoulder to overhead lift 15 pounds. Dr. Raskas also recommended Petitioner be able to change positions frequently to accommodate pain. It was Dr. Raskas's opinion the work restrictions should be permanent and Petitioner was at MMI.

Petitioner was seen again by Dr. James Stiehl on May 11, 2015 for an evaluation. The doctor noted Petitioner had a prior history of back problems a couple of years before the first date of accident in 2013 and had responded well to physical therapy. Petitioner had been off work since January of 2015. Dr. Steihl noted the MRI was pristine for this age group and did not see any problems. In his opinion, Petitioner had an excellent prognosis for a full recovery. He advised against cortisone injections, recommended physical therapy for 6-8 weeks and indicated Petitioner is capable of light duty. Dr. Stiehl stated Petitioner continues to have chronic back pain at this time. The doctor expressed concern the time off work had been extended and Petitioner had not been in physical therapy, which was the optimal treatment. He stated it was difficult to know the exact causation as Dr. Raskas's medical records were not available for review. (R.Ex.B).

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT ON ALL DISPUTED ISSUES:

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

The Arbitrator finds Petitioner sustained an injury on December 3, 2013. Following Petitioner's work injury on December 3, 2013, Petitioner underwent conservative care in the form of physical therapy and epidural steroid injections. Petitioner was on light duty for 9-10 months. He returned to full duty on October 6, 2014 and Dr. Kovalsky's diagnosis at that time was lumbosacral strain and resolved mechanical back pain. (P.Ex.4). Both Dr. Kovalsky and Dr. Stiehl related the injury to Petitioner's accident at work.

Based on the evidence presented, the Arbitrator finds Petitioner's injuries were causally related to his work accident on December 3, 2013.

With regard to the second date of injury, the Arbitrator finds the Petitioner failed to satisfy his burden of proof that his current condition of ill-being is causally related to the alleged accident on December 17, 2014. During cross-examination, Petitioner admitted nothing specific happened on December 17, 2014 to cause his back to hurt. (T. 29). Petitioner did not seek medical attention until February 13, 2015, at the direction of his attorney. (T. 32). Petitioner saw Dr. Raskas on three separate occasions, but no where in Dr. Raskas's reports does he relate Petitioner's current condition to his work activities or to a work injury. Dr. Raskas did not describe any mechanism of Petitioner's job duties that could have caused his current condition of ill-being.

When Petitioner saw Dr. Stiehl on May 11, 2015, the medical records from Dr. Raskas were unavailable. Dr. Stiehl examined the Petitioner and noted the back pain Petitioner was experiencing was chronic in nature. This is evidenced by a prior history of back problems a couple of years before the first date of accident in 2013 that had responded well to physical therapy. Petitioner had another issue with his back in December of 2013 that was also resolved with physical therapy. In Dr. Stiehl's opinion, Petitioner continues to have chronic back pain that he believes could be resolved once again with physical therapy. (R.Ex.B). Dr. Raskas furthers this opinion of chronic back pain by placing permanent restrictions on Petitioner.

Due to the Petitioner's testimony, coupled with the lack of definitive causation opinion and the objective evidence of the annular tear being present in the MRI taken prior to December 17, 2014, the Arbitrator finds the Petitioner failed to satisfy their burden of proof that Petitioner's current condition of ill-being is casually related to the alleged incident of December 17, 2014.

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

The Arbitrator finds all of Petitioner's medical treatment was reasonable with respect to the injuries caused by the December 3, 2013 accident.

The Arbitrator finds there is no causal connection between the alleged December 17, 2014 injury and Petitioner's current condition of ill-being. The Respondent is not liable for medical expenses after December 17, 2014.

Issue L: What is the nature and extent of the injury?

Pursuant to §8.1b of the Act, permanent partial disability from injuries that occur after September 1, 2011 are to be established using the following criteria: (i) the reported level of impairment pursuant to subsection (a) of the Act; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the

treating medical records. 820 ILCS 305/8.1b. The Act provides that, "No single enumerated factor shall be the sole determinant of disability."

Level of Impairment: Neither Party submitted an AMA rating. The Arbitrator gives no weight to this factor.

Occupation: Petitioner continues to work for Respondent; however, his functional capacity is mildly limited by his permanent restrictions which allow him to perform light duty work, and Petitioner requires occassional assistance to perform tasks in his light duty position. Accordingly, the Arbitrator places great weight on this factor.

Age: Petitioner was 62 and 63 years old at the time of his injuries. The Arbitrator places little weight on this factor.

Earning Capacity: While there is no direct evidence of reduced earning capacity contained in the record; based on the Petitioner's injuries The Arbitrator thus gives no weight to this factor.

Disability: As a result of his accidental injury of 12/3/13 the medical records indicate the Petitioner has been placed on full time light duty which is being accommodated by the Respondent. The Arbitrator gives great weight to this factor.

Based on the foregoing, the Arbitrator finds that Petitioner on December 3, 2013 sustained serious and permanent injuries that resulted in the 6% loss of his body as a whole.

Furthermore, the Arbitrator finds the Respondent failed to meet their burden of proof and the Petitioner's current condition of ill-being is not causally related to the second alleged injury of December 17, 2014. Therefore, Respondent is not entitled to an award of permanent partial disability or any other benefits with respect to the second date of injury.

STATE OF ILLINOIS)
) SS.
COUNTY OF ROCK ISLAND)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Shannon Wilson,

Petitioner,

vs.

NO: 11 WC 47868

State of Illinois Department of Human Services,

17IWCC0003

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 20, 2015, is hereby affirmed and adopted.

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

17IWCC0003

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 11 2017
TJT:yl
o 12/19/16
51

Thomas J. Tyrrell

Kevin W. Lamborn

Michael J. Brennan

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

WILSON, SHANNON
Employee/Petitioner

Case# **11WC047868**

DEPARTMENT OF HUMAN SERVICES
Employer/Respondent

17IWCC0003

On 10/20/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.11% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2028 RIDGE & DOWNES LLC
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415 N E JEFFERSON AVE
PEORIA, IL 61603

0988 ASSISTANT ATTORNEY GENERAL
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SPRINGFIELD, IL 62706

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

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

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

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

OCT 20 2015

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

STATE OF ILLINOIS)
)SS. 17IWCC0003
COUNTY OF ROCK ISLAND)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Shannon Wilson
Employee/Petitioner

v.

Department of Human Services
Employer/Respondent

Case # 11WC 47868

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gregory Dollison**, Arbitrator of the Commission, in the city of **Rock Island, Illinois**, on **7/9/2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

17IWCC0003

FINDINGS

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

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

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

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

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

In the year preceding the injury, Petitioner earned **$39,226.20**; the average weekly wage was **$754.35**.

On the date of accident, Petitioner was **55** years of age, ***married*** with **0** children under 18.

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

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

Respondent is entitled to a credit under Section 8(j) of the Act for all medical bills paid through it's group medical plan. Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit. But, by so doing, Respondent is responsible for Petitioner's co-pays.

ORDER

Respondent shall pay reasonable and necessary medical services of $9,270.00, as provided in Section 8(a) and 8.2 of the Act. Respondent shall pay any unpaid, related medical expenses according to the fee schedule and provide documentation with regard to said fee schedule payment calculation to Petitioner.

Respondent shall authorize the treatment as prescribed by Dr. Stachniw.

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

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

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

Signature of Arbitrator

10/13/15
Date

ICArbDec19(b)

OCT 20 2015

FINDINGS OF FACTS:

Petitioner testified that she became employed by Respondent in 2000. Petitioner indicated that her job was clerical/receptionist. Petitioner stated that she was laid off in 2002. During that lay off, she worked for the Department of Corrections, Henry Hill as timekeeper. She spent approximately 14 weeks doing that job. As the timekeeper, she had to sign in and sign out each employee which totaled about 360 a day. Petitioner provided that she primarily used her right hand to write the names and she would then have to file them. Petitioner worked at the desk from 2005 to 2013. At that time, she was promoted to a case worker.

Petitioner testified that there were seventy-five (75) to two-hundred (200) people who would come to the front desk on a daily basis. They would ask questions about applying their benefits and other processes. For each of those individuals, she would have to look up their file on the computer. As an office assistant, she would have to type (keyboard), file, handwrite items, and work the file, all of which involved use of both the left and right hand.

Petitioner described her desk as being approximately 3 feet high. Her computer keyboard sat on that desk. She had to reach across the desk to a window which was higher from floor than the desk. At trial, she demonstrated that her reach was approximately 2 feet higher than the desk while leaning over the desk. Petitioner provided that she also leaned the left forearm and elbow on the desk when she worked.

Petitioner testified that her job duties also involved accepting phone calls. Petitioner provided that received between two-hundred (200) and three-hundred (300) telephone calls. Those too required her to look up the individual on the computer. Sometimes the conversations were short, ten (10) seconds, merely looking for the identity of the case worker or other times they were appreciably longer, five (5) to ten (10) minutes. Petitioner also stated that recipients or potential recipients would also walk in without appointment.

Petitioner testified that in 2009 she was required to move a substantial amount of material to a different office. She had to clear the shelves of files to be sent and box them. The boxes were heavy and were lifted more than once before she was done with them.

Her duties were to handle the case and transfer files. There were 25 file cabinets. The files were in expanding folders of various sizes and weights. When dealing with handling the file, she would have to pull them out no less than 2 times and sometimes 4 or 5 times in handling. She demonstrated how she reached down with her palms to grasp the files. She would grab the file in one or both hands and physically pull it up out of the cabinet. Sometimes the files got caught and had to be pulled forcefully.

In 2010, she transferred 450 transcripts out. She got 581 files in cases and 1,108 pages. She had to pack 103 boxes, each box being assembled by her and weighing anywhere around 40 to 50 pounds. Petitioner testified in detail to the boxes she packed and moved, office supplies she carried and unpacked, the number and times she pulled files in and out of boxes or file drawers.

Her duties also involved receiving office supplies which she would have to place on shelves. That involved grasping and picking things up with one or both hands. There were also pamphlets, brochures, paper and folders that she had to unpack and put on shelves.

Medical records submitted show Petitioner was seen by Dr. John Mahoney of Midwest Orthopedic on May 6, 2008. At that time Petitioner complained of increased numbness and tingling in both hands, more left

than right. Petitioner provided that the symptoms had been present for two months and were bothersome at night and while driving. She had been dropping things and had difficulty with fine motor tasks. Dr. Mahoney concluded that she had bilateral carpal tunnel syndrome with mild signs of left cubital tunnel syndromes. The doctor fitted her for a cock-up splint and ordered an EMG/NCV study. The study when performed on May 30, 2008 demonstrated normal findings with no evidence of right or left median or ulnar neuropathy nor any left upper limb radiculopathy. (RX 3) Petitioner testified that she never returned to the doctor's office nor did she did see Dr. Mahoney after the negative EMG.

On July 20, 2010 Petitioner filed a "Workers' Compensation Employee's Notice of Injury" informing Respondent she injured her "right and left hands, wrists" while "picking up items, typing, writing, filing." Petitioner described her duties as computer work, typing, filing, purging, stocking paper, supplies." (RX 1)

Petitioner sought medical care on August 11, 2010 with Dr. Myron Stachniw of Midwest Orthopedic Services. She complained of a gradually increasing pain, weakness and numbing in her hand with the repetitive constant work with both hands. She described the pain as throbbing and had symptoms of weakness and numbness. Since the problem started, it became worse, causing her to wake up in her sleep. She tried braces on her own. He also noted that on the left side the 4th and 5th fingers would go to sleep when her arm was flexed. On physical exam, he noted atrophy of the thenar eminence and positive Tinel's on both wrists and the left elbow. He was certain that she was suffering from carpal tunnel syndrome and probable left cubital tunnel syndrome. (PX 1)

On August 19, 2010, Dr. Stachniw completed his initial workers' compensation medical report noting his diagnosis and prognosis. Dr. Stachniw referred Petitioner to Borislav Nikolov MD of Galesburg Clinic who obtained a history of complaints of numbness and paresthesia in both hands with pain in the wrist and fingers, that her left hand was worse than her right. He performed the EMG which showed mild right carpal tunnel syndrome. There was no evidence of medial focal neuropathy on the left side. There was some denervation changes in the primary C6 myotome on the left raising question about cervical radiculopathy. His conclusion was that the study performed was abnormal with evidence of right medial focal neuropathy at the wrist but no evidence of left carpal tunnel syndrome or ulnar neuropathy. (PX 1)

Petitioner returned to Dr. Stachniw on November 16, 2010 and told her that he concluded she had right carpal tunnel syndrome and probably radiculopathy on the left. He was of the opinion she would need to have a ligamentous release on the right. He suggested an MRI of the cervical spine. (PX 1)

On September 22, 2010 Petitioner underwent a cervical MRI at OSF St. Mary's. Dr. Williams who performed the test, noted at C6-7 that there was a broad based posterior disc protrusion measuring about 3 mm in thickness which mildly effaced the anterior dural sac but did not significantly compromise the spinal canal or neural foramina. (PX 2)

On October 4, 2010, Dr. Stachniw reviewed the MRI noting some arthritis in the neck. The doctor also noted Petitioner still had numbness on the left side even though the electrodiagnostic studies didn't show any radiculopathy. He felt that she had carpal tunnel on the right and indicated, "I told her she should have that done." The doctor indicated he advised her not to wait more than nine (9) months before getting a carpal tunnel release. At that visit, the doctor started her on home cervical traction. (PX 1)

On December 6, 2010, Dr. Stachniw noted that Petitioner's left wrist was still symptomatic. He was sure she had carpal tunnel syndrome and ordered a MRI. The MRI when completed on December 15, 2010 demonstrated 1.) prominent size and edema in the median nerve, likely related to carpal tunnel syndrome; and, 2.) mild areas of edema in the distal navicular and in the lunate, arthritic in nature. (PX 1)

On December 20, 2010, Dr. Stachniw reviewed the MRI noting some arthritis and swollen median nerve, which he indicated was consistent with carpal tunnel syndrome. The doctor provided that Petitioner should be treated with outpatient surgery. He felt that her condition was work-related. (PX 1)

Petitioner testified and the medical records submitted show Petitioner continued to treat conservatively for her carpal tunnel syndrome diagnoses. Dr. Stachniw continues to recommend surgery.

At Respondent's request, Petitioner underwent a Section 12 examination with Dr. Chris Wottowa on August 1, 2012. In his report signed on August 8, 2012, Dr. Wottowa agreed that it appears she has bilateral carpal tunnel syndrome and possibly cubital tunnel syndrome. As to whether she reached maximum medical improvement, Dr. Wottowa stated that she had not as she was still suffering the symptoms of the irritation of her median nerve and the ulnar nerve. In his report, Dr. Wottowa indicated he was asked to determine whether the work caused, aggravated or accelerated her condition. The doctor responded, "By her own description, her symptoms have been aggravated, but I hesitate to say that they were caused by her work activities because it is primarily clerical work". The doctor went on to state that activities such as reading a newspaper, talking on the phone at home, preparing meals or driving a car could have been aggravating factors as well. (RX 2)

Dr. Stachniw testified via deposition in this matter. The doctor provided that when he first saw Petitioner, she described her job as an office assistant, i.e., "...computer work, administrative work, will move stuff around the office, just does everything in the office...repetitive, constant work with her hands." Dr. Stachniw was asked to assume the following facts: "...[Petitioner] began work for the State of Illinois in an office assistant capacity in 2000. And in that job she was required to do typing, which I believe is computer work, keyboarding technically,...for a good part of the day. She did writing with her dominant right hand. She did filing, and by that I mean she would assemble files, pick them up, pull files apart in the drawer, and shove files in. And during the course of her day that was primarily what she did eight hours a day..." When asked his opinion as to whether or not there was a causal relationship between the above referenced and Petitioner's bilateral carpal tunnel syndrome, the doctor testified that same either caused or aggravated her conditions. (PX 6, pgs. 12-14)

In support of the Arbitrator's decision relating to (C.) Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent and (F.) Is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds the following:

The Arbitrator finds that Petitioner sustained an accident that arose out of and in the course of her employment on July 20, 2010 and that her bilateral carpal tunnel and cubital tunnel syndrome conditions of ill-being are causally related to said conditions.

It is well known that the work activity need not be the major cause. A workman's existing physical structure, whatever it may be, gives way under the stress of his usual duties establishing a compensable injury. ***LaClede Steel Company v Industrial Commission***, 6 Ill.2d 296 (1955) The employer is not relieved of liability under the Illinois Workers' Compensation Act because an injury arose from a pre-existing condition. ***AC&S v Industrial Commission***, 304 Ill.App.3d, 875, 882 (2000) The Petitioner need to show only that some act of the employment was a causative factor not the sole or principle cause of the resulting injury. ***Teska v Industrial Commission,*** 266 Ill.App.3d, 740, 742 (1994)

In this case, Petitioner's testimony regarding her work activities is unrebutted. Both Dr. Stachniw, Petitioner's treating physician, and Respondent's evaluating physician, Dr. Wottowa, provided an affirmative causal connection opinion. Specifically, Dr. Stachniw noted on December 20, 2010, that her condition was work-related. The doctor also confirmed same during his deposition when he testified that her work activities

either caused or aggravated her conditions. Although Dr. Wottowa indicated he hesitated to say that her conditions were caused by her work activities, he also provided "By her own description, her symptoms have been aggravated..." As noted above, Petitioner's testimony regarding her work activities is unrebutted. The Arbitrator notes that both of the doctors opinions were rendered without specific knowledge of what Petitioner's job duties entailed or their frequency.

As summarized in ***Williams v Industrial Commission***, 244, Ill.App.3d, 204, 209 (1993), an employee suffering from a repetitive trauma injury must point to a date within the statute of limitations on which both the injury and its causal link to the employee's work became plainly apparent to a reasonable person. Here, clearly Petitioner did not appreciate that her job caused or contributed to her bilateral carpal tunnel and left cubital tunnel syndromes until July 20, 2010. There is no indication she was aware that the carpal tunnel and ulnar nerve condition described by Dr. Mahoney in May 2008 was related to her job. The medical inquiry history fails to reflect that she attributed her wrist pain and numbness to work. No reference was made in the records that Petitioner's condition was related to a work injury. In addition, she continued to perform the same activities aggravating that condition every workday, whether it was with the Department of Human Services or the Department of Corrections. There is no evidence presented that Petitioner knew her bilateral carpal tunnel and left ulnar nerve condition were caused by her job.

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

Petitioner submitted the following bill:

Midwest Orthopedic Specialists/Myron Stachniw, MD - $647.00	
Borislov Nikolov, MD	
9/8/2010	$1,575.00
5/8/2013	no bill furnished
OSF St. Mary's Medical Center	
9/22/2010 MRI	$2,908.00
12/14/2010 MRI	$3,199.00
Jeffery Hershkowitz, MD	
7/24/2013	$ 124.00
Clinical Illinois Radiologists	
9/22/2010	$ 451.00
12/14/2010	$ 356.00
TOTAL	$9,270.00

Having found the requisite accident and casual connection, the Arbitrator finds that Respondent shall pay the above referenced medical providers. Said payment shall be made consistent with the medical fee schedule. If payment has been made by group insurance, funded in whole or in part by Respondent, Petitioner shall be held harmless for those payments made. In addition thereto, Respondent shall reimburse Petitioner any out of pocket medical expenses and co-pays should group insurance have paid her medical bills.

In support of the Arbitrator's decision relating to (K.) Is Petitioner entitled to any prospective medical care, the Arbitrator finds the following:

Petitioner's treating physician, Dr. Stachniw, prescribed bilateral carpal tunnel surgery and considered doing an ulnar nerve transposition based upon his findings. Respondent's evaluating physician, Dr. Wottowa, agreed that all three surgeries were necessary.

Having found that Petitioner's conditions of ill-being is causally related to her employment, the Arbitrator finds that Respondent shall authorize the treatment as prescribed by Dr. Stachniw.

STATE OF ILLINOIS)
) SS.
COUNTY OF WILL)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

George L. Campbell,

Petitioner,

vs.

NO: 10 WC 18550

Central Freight Lines, Inc.,

17IWCC0004

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 19, 2015, is hereby affirmed and adopted.

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

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

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

DATED: JAN 11 2017
TJT:yl
o 1/10/17
51

Thomas J. Tyrrell

Kevin W. Lamborn

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CAMPBELL, GEORGE L
Employee/Petitioner

Case# **10WC018550**

CENTRAL FREIGHT LINES INC
Employer/Respondent

17IWCC0004

On 5/19/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

2998 QUINN MEADOWCROFT & MARKER
JASON A MARKER
400 W BOUGHTON RD SUITE 200
BOLINGBROOK, IL 60440

2965 KEEFE CAMPBELL BIERY & ASSOC
SEAN C BROGAN
118 N CLINTON ST SUITE 300
CHICAGO, IL 60661

STATE OF ILLINOIS)
)SS.
COUNTY OF WILL)

17IWCC0004

☐ 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

George L. Campbell
Employee/Petitioner

v.

Central Freight Lines, Inc.
Employer/Respondent

Case # **10** WC **18550**

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 **New Lenox**, on **April 9, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **February 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 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 **$36,566.40**; the average weekly wage was **$703.20**.

On the date of accident, Petitioner was **56** years of age, ***married*** 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

Petitioner failed to meet his burden of proof on the issues of accident. Accordingly, Petitioner's claim for 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

5/15/15
Date

MAY 19 2015

17IWCC0004

FINDINGS OF FACT

This case involves a petitioner claiming injuries to his low back and neck due to an alleged accident on February 19, 2010. Petitioner's claimed accident is both traumatic and repetitive in nature. Respondent disputes this case based on the following issues: 1) accident, 2) notice, 3) causation, 4) TTD, 5) medical expenses and 6) nature and extent.

On February 19, 2010, George Campbell ("Petitioner") worked for Respondent as a pickup and delivery truck driver at the Respondent's Bolingbrook facility. He began working for Respondent in October 2008. Prior to working for Respondent, he worked as a truck driver for UPS for 30 years. He testified his job duties while working for Respondent involved making various stops, loading, unloading, picking up freight, and making deliveries. Petitioner approximated that 90% of his job was driving and the remaining 10% was unloading/loading his truck. He testified 90% of the unloading/loading was done with a fork truck and 10% was done by hand. He worked Monday through Friday. He had various routes and would make multiple stops each day.

Petitioner drove an International single axle. He testified the air glide driver seat was fine at first but that it began leaking air. Towards the end of 2009, he testified he would bounce up and down while driving and hit his head on the ceiling of the cab because of the air leak. He also testified there were problems with the door of his trailer in late 2009 and the brakes were no good. He further testified he reported the issues with the seat, trailer door, and brakes to Respondent via driver vehicle reports (DVR), which were required to be completed at the beginning and end of each day. . Petitioner offered as evidence 16 photocopies of carbon copies of DVRs with nonconsecutive dates from June 24, 2009 through August 11, 2009. Of the 16 reports from the one-and-a-half month period in 2009, five of them mention issues with a trailer door not closing easily or getting stuck. None of the reports indicate Petitioner injured himself while opening/closing the trailer door. None of the DVRs note any issues with Petitioner's air glide driver seat. Petitioner testified he reported similar issues with his truck and trailer after August 11, 2009, but he did not have any DVRs after August 11, 2009. He testified he may have had copies at one time, but they may have been thrown away. He also testified that he took his truck to a repair shop in August 2009 but repairs were never made and Petitioner offered no documentation to corroborate this claim.

Petitioner testified he began feeling neck and low back pain while working for Respondent and it gradually got worse. He testified he first sought medical attention for his complaints in January 2010. He further testified he was unable to do daily activities in January 2010 without pain. . He testified that when he saw Dr. Masood in January, 2010, he specifically told the doctor his symptoms were from lifting doors and his general job duties with Respondent. Following a February 2010 MRI, Petitioner testified Dr. Masood diagnosed a herniated disc and the doctor felt Petitioner was in bad shape.

Petitioner testified he spoke to the general manager of the Bolingbrook facility, Tom Kovalik, about his pain. He testified the conversation occurred in Mr. Kovalik's office at the Bolingbrook facility on February 19, 2010. That day, at approximately 9:30 a.m., Petitioner testified he was preparing to load his trailer at the Bolingbrook terminal before making his run. He further testified he attempted to lift his trailer door using what he characterized was excessive force and felt a sharp pain in his back. He testified he told Mr. Kovalik about the incident the morning it occurred. Petitioner testified Mr. Kovalik asked whether medical attention was needed, but Petitioner conveyed he was already seeing a doctor for his condition. Petitioner confirmed it was

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Respondent's policy to complete an incident report upon an employee's reporting of a work injury, but Petitioner testified Mr. Kovalik did not ask him to complete an incident report and he was unsure whether Mr. Kovalik eventually completed an incident report.

Petitioner's time logs indicate he worked a full, 8.75-hour day on February 19, 2010. RX # 9. Petitioner then worked 44.42 hours throughout the week of February 22—February 26, 2010, 45.08 hours throughout the week of March 1—March 5, 2010, and 34.65 hours throughout March 8—March 11, 2010. RX # 9.

Petitioner testified he spoke with Mr. Kovalik a second time about his symptoms on March 15, 2010, the Monday after the terminal closed. He testified he told Mr. Kovalik that "the back injury was not over. And that, you know, we'll have to wait and see what happens." Petitioner further testified he told Mr. Kovalik on March 15, 2010 he might never be able to drive a truck because his doctor recommended he file for disability.

Tom Kovalik

Tom Kovalik testified via deposition on March 25, 2015. RX # 6. Mr. Kovalik is employed with Respondent as a manager of partnership relations. He began working for Respondent in May 2009 as a terminal manager at the Bolingbrook facility where Petitioner worked as a daytime pickup and delivery driver. He was the only manager of the facility from the time he was hired until it closed in March 2010. As terminal manager, Mr. Kovalik managed three supervisors, two clerical workers, approximately 14 to 19 drivers, and approximately eight to 10 part-time dockmen. Mr. Kovalik was responsible for the upkeep of the building and equipment and handled personnel issues. He was also the focal point for handling workplace injuries. When work injuries were reported, Mr. Kovalik would enter the information into his computer and send it to the Safety Department and his immediate manager.

Mr. Kovalik testified Petitioner never reported he injured his back or neck at work. He testified he first became aware Petitioner was claiming a work-related injury well after the Bolingbrook facility had closed when he spoke with one of Respondent's attorneys in 2010. He testified that had Petitioner reported an injury, he would have sat down with Petitioner, assessed whether medical attention was needed, and created an incident report. Mr. Kovalik further testified that when Petitioner previously failed to report a work-related injury, disciplinary action was initiated.

Mr. Kovalik testified the Bolingbrook terminal employees were notified of its closing on or about March 15, 2010 but Petitioner was not present at the meeting. Mr. Kovalik, however, spoke to Petitioner privately later that day in his office. Mr. Kovalik conveyed to Petitioner the terminal was closing and noted:

> **I knew there were other personal matters discussed. George says he was -- he may not be working much longer at that time. I didn't really get into it. I knew that his wife was ill, and I didn't expand on anything like that. It might have been for reasons of her health. It could have been reasons for his health. I didn't develop that.**

Mr. Kovalik confirmed Petitioner did not report a work-related injury to his back or neck during the private meeting on or about March 15, 2010 or at any time while he was employed by Respondent.

Pre-2010 Medical Treatment

On direct examination, Petitioner testified, prior to his incident on February 19, 2010, he had no previous back

problems and he only complained of back pain to his family doctor possibly once or twice in the 15 years prior to February 19, 2010. He testified he never had any x-rays of his low back prior to 2010. On cross examination, however, Petitioner testified he had back strains that started getting more severe in March 2009. He also testified he was having pain in his low back during June, July, and August 2009 while he was lifting his trailer door, but it did not occur to him that his symptoms could be related to his work duties. Last, he testified he strained his back while working for UPS but "nothing was ever filed or no workmen's comp."

On September 10, 2002, Petitioner presented to Internal Medicine and Family Practice, S.C. complaining of back pain. He stated the company doctor had him doing physical therapy for 1.5 weeks but it was not helping much. On exam, he complained of tenderness over the lumbosacral area. The doctor assessed musculoskeletal pain and recommended an MRI of the thoracolumbar spine to rule out a disc herniation. PX #13, Exhibit #2.

On March 23, 2004, a handwritten progress note indicates "Rush-Copley – Aurora ER. Left-sided tingling and numbness. If admitted call Sonya." Id.

On March 21, 2009, Petitioner returned to Internal Medicine and Family Practice complaining of inability to sleep and neck pain. He was diagnosed with musculoskeletal pain. Id.

On July 25, 2009, Petitioner returned to Internal Medicine and Family Practice and complained of left shoulder and neck pain that radiated to both shoulders. Id.

On August 24, 2009, Petitioner returned to Internal Medicine and Family Practice. He complained of a cough, low back pain, and head congestion. Id.

Petitioner had a medical examination for commercial driver fitness determination on October 22, 2009. PX #1. Petitioner testified he completed the health history portion of the report and checked "No" for spinal injury or disease and "No" for chronic low back pain.

Post-2010 Medical Treatment

On January 23, 2010, Petitioner presented to Internal Medicine and Family Practice. He complained of tenderness over the cervical and lumbar spine. X-rays of the lumbar and cervical spine were recommended. PX #6. The records from this date does not note either a trailer door lifting event or Petitioner hitting his head on the inside of his cab as a source of pain.

On February 5, 2010, Petitioner presented to Provena Saint Joseph Medical Center. Cervical spine x-rays revealed moderate degenerative disc changes at C4-5 and C5-6 but normal anatomical alignment. Lumbar spine x-rays revealed very mild spondylosis which had progressed when compared to a prior study from 2007. Chest x-rays, which were completed due to chronic obstructive pulmonary disease (COPD), revealed mild changes, and a CT of the chest revealed a small 6 mm pulmonary nodule in the base of the right lung. PX #7.

On February 20, 2010, Petitioner presented to Dr. Masood. Petitioner complained of generalized neck and back pain and stated he was unable to drive a truck. X-ray results were reviewed. On exam, he complained of tenderness over the cervical and lumbar spine. The doctor ordered MRIs of the cervical and lumbar spine. PX # 6. There is no mention of any complaints of pain related to lifting a trailer door or Petitioner striking his head

on the inside of his cab in Dr. Masood's February 20, 2010 medical record.

On February 27, 2010, MRIs of the lumbar and cervical spine were completed at Provena St. Joseph Medical Center. The radiologist assessed a very tiny central disc protrusion at L4-5, without any spinal stenosis or nerve root displacement, and a mild amount of osteophyte formation in the right paracentral and right lateral location of L5-S1 causing minimal encroachment on the right neural foramen fat. Regarding the cervical spine MRI, the radiologist assessed degenerative changes at C4-5 and C5-6 with mild stenosis and posterior impression on the thecal sac but without any cord compression. Last, the radiologist assessed a mild disc protrusion at C6-7 but with no spinal stenosis. PX #7. There were no acute or traumatic findings in these diagnostic tests.

On March 20, 2010, Petitioner returned to Dr. Masood. Petitioner stated he was unable to work anymore. He complained of pain in his extremities and neck as well as back pain that radiated to his legs. PX # 6.

On April 27, 2010, Petitioner returned to Dr. Masood complaining of neck and back pain that radiated sideways. He stated he thought his pain got worse with the job he did. No specific trauma or event was outlined. Dr. Masood recommended a neurosurgical consult. Id.

On August 11, 2010, Petitioner presented to Dr. Lorenz for an initial evaluation. He stated he was in good health until February 19, 2010, when he forced a door open in the back of his truck and hurt his back. Additionally, Petitioner stated there were numerous times where he was bounced around on a malfunctioning air glide chair causing him to strike the top of the cab as he was driving. PX #9.

Petitioner completed a questionnaire in which he noted he had no previous problems with his low back, his then current pain did not radiate, and the date of his first spine pain attack was February 19, 2010. RX # 10.

On exam, Petitioner complained of significant pain with all essential movement and on touching of the upper and lower back, but the doctor noted Petitioner's neurological examination was essentially normal. Dr. Lorenz diagnosed chronic pain syndrome and opined it was probably aggravated by the single lifting incident on February 19, 2010. Dr. Lorenz recommended a repeat cervical spine MRI and a follow-up with pain management but noted Petitioner was definitely not a surgical candidate. Dr. Lorenz opined Petitioner should not work. On August 16, 2010, a cervical spine MRI was completed. The radiologist assessed degenerative changes at C4-5 and C5-6, moderate stenosis at C5-6 greater on the left, and neural foraminal and mild canal stenosis at C4-5 and C6-7. On September 1, 2010, Dr. Lorenz reviewed the cervical MRI and referred Petitioner to hematology/oncology to evaluate the etiology of the edema in C4-5 and C5-6. PX #9.

On February 10, 2011, Petitioner presented to Dr. Kevin Diel of Florala Clinic in Alabama. Petitioner noted he recently moved to the area and needed a doctor to manage multiple medications. He reported a past medical history of COPD, hypertension, rheumatoid arthritis, and depression. Petitioner did not complain of any cervical spine symptoms. Nor did Petitioner attribute any of his problems to a past event at work. The doctor assessed hyperlipidemia, asthma, anxiety, chronic low back pain, depression, insomnia, COPD, hypertension, rheumatoid arthritis, and depression. PX # 11.

On December 1, 2011, Petitioner underwent a functional capacity evaluation (FCE) upon referral from Dr. Litchfield. He stated he was lifting a defective semitrailer roll-up door on February 19, 2010 when it got stuck and he had to forcefully push up and felt a sharp pain in his low back. The therapist opined Petitioner demonstrated consistent performance throughout testing and ability to function in the sedentary physical

demand category for eight hours per day with occasional lifting up to 15 pounds. PX #10.

On December 5, 2011, Petitioner returned to Dr. Lorenz. He stated his back pain was his biggest problem and he was not concerned with his neck pain. He further stated he had not seen an oncologist. Petitioner's neurological exam was normal. Dr. Lorenz noted Petitioner had degenerative changes in his cervical and lumbar spine and opined Petitioner was not a surgical candidate. The doctor further opined Petitioner could work in a sedentary position. Dr. Lorenz recommended a Functional Capacity Assessment and a return to work within those parameters. PX #9.

Dr. Shahid Masood

Dr. Shahid Masood, an internal medicine physician, testified via deposition on March 25, 2015. PX #13. Dr. Masood testified he had been seeing Petitioner since at least 2002. Id. at 31.

Dr. Masood composed a letter to Petitioner dated March 2, 2009; however, the doctor testified that the date was a typographical error as it should have been dated March 2, 2010. PX #3; PX #13 at 17. The doctor wrote that he had reviewed the reports of the cervical and lumbar spine MRIs from February 27, 2010 along with previous medical notes and strongly recommended Petitioner apply for Social Security Disability benefits. The doctor noted the MRIs showed stenosis and disc herniations in the lumbar and cervical spine, but the doctor did not indicate that any of Petitioner's work duties had contributed to his condition. PX #3.

On April 27, 2010, Dr. Masood composed another letter in which he indicated he was treating Petitioner for back pain resulting from a herniated disc he believed may have been caused by his work duties with Respondent. PX #4. The doctor did not indicate Petitioner sustained an acute incident of trauma on February 19, 2010 while lifting a trailer door nor did the doctor note Petitioner reported any problems with the air glide driver seat in his cab. The doctor noted "[a]ccording to Mr. Campbell he had no issues of back pain or any past injuries prior to his employment with Central Freight Lines." The doctor opined Petitioner could no longer work as a truck driver or lift over 10 pounds. Id.

Dr. Masood testified he diagnosed Petitioner with spinal and neural foraminal stenosis after reviewing the February 2010 MRIs, but he admitted he did not review the actual MRI films. PX #13 at 26, 52. Dr. Masood testified he did not recall whether Petitioner reported an acute incident of trauma occurring on February 19, 2010 at his office visit on February 20, 2010 or at anytime during his treatment. Id. at 33. He further testified he did not recall Petitioner reporting any specific injury from or difficulty lifting trailer doors. Id. at 33. Dr. Masood also testified he did not recall Petitioner reporting any injuries caused by bouncing around on a malfunctioning air glide driver seat. Id. at 33-34. Dr. Masood confirmed had Petitioner reported any specific incident, he would have noted it in his reports. Id. at 34. Dr. Masood further confirmed Petitioner's low back condition was likely symptomatic in 2007 when he had his lumbar spine x-rayed. Id. at 39-40. The doctor testified he believes repetitive lifting, pulling, and pushing while working for Respondent caused Petitioner's degenerative condition to become symptomatic, yet he conceded he had no knowledge of the specifics of Petitioner's job duties. For example, Dr. Masood did not know: how much time in an average work day Petitioner spent driving, loading/unloading freight, opening/closing trailer doors, pulling dock plates, hooking/unhooking trailers, etc.; how much force was required to close and open trailer doors; and,the weight of the freight Petitioner lifted or even what freight he was hauling. Id. at 46-47. Dr. Masood confirmed he never reviewed a written job description, nor did he independently confirm the accuracy of any information Petitioner

had provided about his job duties. Id. at 45-46.

Dr. Kevin Walsh

Dr. Kevin Walsh testified via deposition on November 19, 2012. RX #5. Dr. Walsh conducted an independent medical examination on Petitioner on May 8, 2012. Dr. Walsh noted Petitioner had substantial subjective complaints of pain and discomfort in his neck and lumbar spine, a paucity of objective abnormalities, and positive Waddell signs. The doctor noted none of the imaging studies showed anything that could be related to a specific or chronic injury of the lumbar or cervical spine, but rather the studies showed degenerative changes consistent with Petitioner's age. Further, the doctor noted there was no evidence in the medical records that Petitioner suffered an aggravation or acceleration of his pre-existing osteoarthritic spine. Dr. Walsh opined Petitioner did not require any work restrictions or further treatment. Finally, Dr. Walsh opined Petitioner was most certainly not a surgical candidate.

Dr. Walsh testified Petitioner reported his low back pain stemmed from lifting a trailer door on February 19, 2010 while his neck pain stemmed from repetitively striking his head on the roof of his cab while driving due to a bad air seat. RX #5 at 8, 9. Dr. Walsh confirmed Petitioner denied a history of low back or neck pain prior to February 19, 2010 and Petitioner was insistent he could not drive a truck. Id. at 9, 10. Dr. Walsh further confirmed he reviewed Dr. Masood's medical records, in which there was evidence of neck pain predating February 19, 2010, as well as the actual x-ray films and MRI studies of the lumbar and cervical spine from February 2010 and the cervical spine MRI study from August 2010. Id. at 15-18, 21-22.

The doctor testified, upon physical examination, Petitioner indicated he could not perform various range of motion testing due to his reports of pain. Id. at 26-27. The doctor further confirmed the examination was somewhat prolonged as Petitioner had to stop after every range of motion test, reporting pain and discomfort before he could continue. Id. at 28. The doctor testified there was a paucity of objective abnormalities in any of the imaging studies or on physical exam to explain Petitioner's subjective complaints of pain and discomfort. Id. at 28.

Dr. Walsh further testified it was not at all likely Petitioner injured his low back or neck as a result of his work activities as the medical records did not corroborate any injury. Id. at 29. The doctor further testified the degenerative changes seen on the MRIs were consistent with Petitioner's age, and it was consistent with the degenerative process that his symptoms became worse while he was off work. Id. at 29-30.

Dr. Mark Lorenz

Dr. Lorenz testified via deposition on November 7, 2012. PX #14. Dr. Lorenz testified Petitioner reported he was in good health until February 19, 2010 at which time he was forcibly lifting a poorly maintained door on the back of his truck and felt pain his low back and neck. Id. at 8, 23. The doctor also testified Petitioner reported bouncing and striking the top of his head as he drove because of a malfunctioning air glide seat. Id. at 8. Dr. Lorenz testified he reviewed cervical and lumbar spine MRIs from February 27, 2010 and that Petitioner had "significant pain response essentially with everything that we did, all movements and even touching the upper as well as lower part of his back." Id. at 9-12. He also described Petitioner's pain complaints as "extraordinary and unexpected." Id. at 20. The doctor confirmed Petitioner's neurological examination was normal, meaning he had good motor power, good sensory findings, and normal reflexes of the lower and upper extremities. Id. at 12. Following the cervical spine MRI completed on August 16, 2010, Dr. Lorenz testified he recommended

Petitioner see an oncologist. Id. at 13.

Dr. Lorenz testified his second and last examination of Petitioner was on December 5, 2011. Id. at 14. The doctor confirmed Petitioner had not seen an oncologist and Petitioner reported he was not concerned about his neck. Id. at 14. Dr. Lorenz testified Petitioner's examination was unchanged from the previous visit and he recommended an FCE. Id. at 15. Dr. Lorenz further testified he reviewed an FCE completed on December 1, 2011 and instructed Petitioner to continue with activities at the sedentary level based on the evaluation and not to go back to truck driving. Id. at 16-17.

Dr. Lorenz testified Petitioner neither had stenosis nor joint disease, but his diagnoses were chronic back and neck pain. Id. at 17. He testified chronic pain syndrome suggests a greater pain response than one would expect for the pathology at hand and there is nothing really to assess, measure, or quantify the amount of subjective pain someone is experiencing. Id. at 20-21. The doctor confirmed chronic pain syndrome is not his area of expertise and the condition is generally handled by a pain management doctor and is a combination of physical injury, an inflammatory process, and emotional security issues. Id. at 25-26. The doctor confirmed there was nothing fixable through surgery for Petitioner. Id. at 26.

Dr. Lorenz further testified the attempt to lift a gate door on February 19, 2010, as was described by Petitioner, was a competent cause of aggravating the degenerative condition of his neck and low back. Id. at 18.

Vocational Rehabilitiation

Ms. Alla Massat, a certified rehabilitation counselor employed with Encore Limited, testified on behalf of Respondent. After reviewing Petitioner's medical, professional, and educational information, Ms. Massat testified she identified positions for which Mr. Campbell could be qualified.. She testified Petitioner may or may not need computer literacy training depending on his skill level. She then identified job openings within the sedentary demand level by contacting employers directly by phone and researching online. Within the Joliet area, Ms. Massat, identified potential jobs for Petitioner paying up to $18.24 per hour.

Steve Blumenthal, a certified vocational rehabilitation counselor, testified via deposition on behalf of Petitioner. PX #15. Mr. Blumenthal testified Petitioner was not able to return to his job as a truck driver with Respondent as he felt it was not a sedentary position and it was unlikely he could pass a DOT physical. Id. at 23. Mr. Blumenthal testified Petitioner was a candidate for vocational rehabilitation services including testing to evaluate his skills, aptitudes, and interests, computer literacy training, job readiness training, and placement services. Mr. Blumenthal opined that, if the recommended vocational rehabilitation services were provided, Petitioner could likely earn $9.76-$12.71/hour doing clerical work. Mr. Blumenthal confirmed Petitioner's experience and the skills he acquired as a truck driver would lend well to a dispatcher position, if that type of job existed in a stable labor market. Id. at 66-67. Mr. Blumenthal confirmed Petitioner did not report he had looked for any employment since he last worked for Respondent. Id. at 76-77.

Petitioner testified he was not currently working and has not worked since the Bolingbrook facility closed on March 12, 2010 as he was on social security disability. The Social Security Disability documents submitted into evidence indicate Petitioner is on disability for conditions not related to a work. He further testified he has not looked for any work since he last worked for Respondent because he is unemployable. He has a high school diploma and he completed two years of college. He testified he can email, pay bills, and use the internet on the computer. He also testified he has a Facebook account, but he does not know how to use Microsoft Office

programs. He testified he had a resume but it was created by his wife.

Petitioner testified his current neck and back pain was an 8 out of 10. He also testified his current symptoms include forgetfulness and shaky hands and he also treats for hypertension, high blood pressure, COPD, rheumatoid arthritis, and bursitis. He testified he can drive no farther than 60 miles before he starts feeling pain. He further testified he uses a cane. Petitioner testified he is currently taking various medications for anxiety, cholesterol, and pain as well as for his COPD and heart. He testified his family doctor, Dr. Diehl, manages his medications.

CONCLUSIONS OF LAW

1. With regard to the issue of accident, the Arbitrator finds that the Petitioner has failed to meet his burden of proof. In support of this finding, the Arbitrator relies on both the trial testimony and the medical evidence. Specifically, this finding is also based on Petitioner's lack of credibility when comparing his testimony to the medical evidence. The Arbitrator looks to the complete medical records of Dr. Masood which are devoid of any mention of Petitioner injuring his low back or neck at work either on February 19, 2010 or in the performance of his regular duties. When Petitioner was seen on February 20, 2010, the day after the claimed lifting event of February 19, 2010, he did not report any incident occurring the day before. In fact, Dr. Masood testified Petitioner never reported injuring himself on February 19, 2010.

In contrast, when he was seen by Dr. Lorenz on August 11, 2010, at Total Rehab on December 1, 2011, and by Dr. Walsh on May 8, 2012, Petitioner was quite emphatic that he sustained an acute injury to his low back while lifting a "defective" trailer door on February 19, 2010 and he was asymptomatic beforehand. The Arbitrator finds it blatantly incredible that Petitioner would not mention an acute incident of trauma to his primary doctor one day after it had occurred but later report its occurrence to several medical experts.

Not only is there no credible evidence to corroborate Petitioner's claim that his trailer door was broken on or around February 19, 2010, but his report that he was asymptomatic until February 19, 2010 is contrary to the evidence. In closely reviewing Petitioner's treating medical records from Dr. Masood, the first time Petitioner complained of low back or neck conditions was in 2002, which is more than eight years prior to the alleged incident of February 19, 2010. At that time, though he denied ever having a prior work-related low back injury, he was undergoing physical therapy for back pain at the request of a "company doctor" but it was not helping much.

Furthermore, there is no indication in either the testimony or the medical records that Petitioner had any complaints contemporaneous with any particular work activity. This is supported by the testimony of Petitioner's manager, Tom Kovalik, who denied Petitioner ever reported complaints or an injury related to his low back or neck. It is unbelievable that Tom Kovalik would initiate disciplinary action against Petitioner for his failure to report a previous work related injury, but then neglect to document injuries when Petitioner allegedly reported them on February 19, 2010 and March 15, 2010. Based on all these facts, the Arbitrator concludes that the Petitioner did not sustain an accident on February 19, 2010.

2. Based on the Arbitrator's findings with regard to the issue of accident, 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 comment	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
☒ Modify Up	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

John Perski,

Petitioner,

vs.

NO: 14 WC 10485

17IWCC0005

Meyer Aggregate,

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 the issues of causal connection, extent of temporary total disability, extent of temporary partial disability, wages/rate, penalties under §19(k) and §19(l) and §16 attorneys' fees and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Commission*, 78 Ill.2d 327, 399 N.E.2d 1322 (1980).

The Commission notes that Dr. Cummins found Petitioner at maximum medical improvement on November 5, 2014 and released him to return to work at full duty. The Commission affirms the Arbitrator's finding of temporary total disability from December 6, 2013 through November 5, 2014, 47-6/7 weeks. From that point on, Petitioner would only be entitled to maintenance benefits if he performed a valid job search. The Arbitrator found Petitioner had not performed a valid job search. Px13 is Petitioner's job search log and only 5 employers are listed as contacted. The Commission affirms the Arbitrator's finding that Petitioner failed to perform a valid job search in order to be entitled to maintenance benefits.

Regarding average weekly wage, the Arbitrator found that the payment and acceptance of $1,231.00 for a 40-hour workweek is the best proof of Petitioner's average weekly wage. The Arbitrator noted that the wage statement, Px10, showed wage information for the period from December 7, 2012 through November 29, 2013 (51 weeks) and that Petitioner worked 40 weeks in that period. There is no wage information for 11 weeks; between January 4, 2013 and February 8, 2013 (5 weeks), between February 16, 2013 and March 8, 2013 (3 weeks), between April 6, 2013 and April 19, 2013 (2 weeks) and between September 28, 2013 and October 4, 2013 (1 week). Petitioner testified he did not work the periods noted due to inclement weather, below freezing. The Arbitrator found Petitioner did not provide sufficient evidence that he was unable to work during those periods due to inclement weather or due to a State of Illinois contract arrangement. The Commission affirms the Arbitrator's finding of average weekly wage of $1,231.00.

The Commission notes that Petitioner testified that most of his medical expenses have been paid, except for one bill. Petitioner was shown Px8, a medical bill summary and a bill attached for anesthesia services of $1,443.08 due to Barrington Anesthesia Associates for a date of service March 20, 2014, the date of his left shoulder arthroscopy (Tr 35-36). Petitioner testified that bill remains due and owing (Tr 36). Px8 also contains a series of photocopied receipts from Walgreens for prescription expenses totaling $17.54, which Petitioner had never been reimbursed for (Tr 36). The Commission awards Petitioner medical expenses of $1,460.62 ($1,443.08 + $17.54). The Commission also grants Respondent §8(j) credit for any amounts paid by the group health insurance carrier and Respondent is to hold Petitioner harmless for any amounts paid.

Regarding temporary partial disability, the Commission notes that Petitioner testified he became employed with Durham School Services as a school bus driver on August 18, 2015, a part-time job paying $16.00 per hour. The Arbitrator awarded TPD benefits for the period from August 16, 2015 through November 14, 2015. The August 16, 2015 date is from Px14, earning statements indicating when the pay period began. The Commission finds that temporary partial disability started from August 18, 2015, when Petitioner actually started working for Durham. The Commission also notes that the Arbitrator did not explain why he awarded TPD benefits only through November 14, 2015 and there is nothing in the record that corresponds with that date. The Commission finds that TPD benefits should have been awarded through February 13, 2016, the last pay period end date noted in Px14. Therefore, the Commission finds that Petitioner was entitled to temporary partial disability benefits from August 18, 2015 through February 13, 2016.

According to the Earning Statements from Durham School Services, Px14, Petitioner worked the following pay periods and had earnings in the following amounts:

Pay Period Beginning:	Pay Period Ending:	Gross Pay During Period:
8-16-15	8-22-15	$230.22
8-23-15	8-29-15	$291.49
8-30-15	9-5-15	$318.08

9-6-15	9-12-15	$354.11
9-13-15	9-19-15	$345.49
9-20-15	9-26-15	$319.64
9-27-15	10-3-15	$304.23
10-4-15	10-10-15	$364.61
10-11-15	10-17-15	$349.75
10-18-15	10-24-15	$396.41
10-25-15	10-31-15	$337.92
11-1-15	11-7-15	$709.94
11-8-15	11-14-15	$415.84
11-15-15	11-21-15	$409.69
11-22-15	11-28-15	$141.44
11-29-15	12-5-15	$397.44
12-6-15	12-12-15	$402.08
12-13-15	12-19-15	$392.16
1-3-16	1-9-16	$364.96
1-10-16	1-16-16	$292.64
1-17-16	1-23-16	$215.84
1-24-16	1-30-16	$297.76
1-31-16	2-6-16	$343.52
2-7-16	2-13-16	$370.08

For the 24 weeks of pay periods shown above, Petitioner had total earnings of $8,365.34. 24 weeks X $1,231.00 average weekly wage = $29,544.00. $29,544.00 - $8,365.34 = $21,178.66 wage loss X 66 2/3rds = $14,119.10 temporary partial disability benefits owed. The Commission affirms all else.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $820.80 per week for a period of 47-6/7 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.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $14,119.10 for the period of temporary partial incapacity for work under §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $1,460.62 for reasonable, necessary and related 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 shall be given credit for medical expenses that have been paid by the group health insurance carrier and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in §8(j) of the Act.

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 $27,024.63 in TTD benefits, $4,567.56 paid in TPD benefits and $10,000.00 in PPD advance for a total credit of $41,592.19.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $13,400.00. 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 13 2017
MB/maw
o11/17/16
43

Mario Basurto

Stephen J. Mathis

David L. Gore

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

PERSKI, JOHN
Employee/Petitioner

Case# **14WC010485**

17IWCC0005

MEYER AGGREGATE
Employer/Respondent

On 3/15/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.51% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0657 TURNER LAW OFFICES
RICHARD L TURNER JR
107 W EXCHANGE ST
SYCAMORE, IL 60178

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

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

STATE OF ILLINOIS)
)
COUNTY OF COOK)

ILLINOIS WORKERS' COMPENSATION COMMISSION

19(b) ARBITRATION DECISION

JOHN PERSKI
Employee/Petitioner

Case #14 WC 10485

17IWCC0005

V.

MEYER AGGREGATE
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 26, 2016. After reviewing all of the issues, the stipulations of the parties and the evidence, it is hereby found and ordered as follows:

ISSUES:

A. ☐ Was the respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?

B. ☐ Was there an employee-employer relationship?

C. ☐ Did an accident occur that arose out of and in the course of the petitioner's employment by the respondent?

D. ☐ What was the date of the accident?

E. ☐ Was timely notice of the accident given to the respondent?

F. ☐ Is the petitioner's present condition of ill-being causally related to the injury?

G. ☒ What were the petitioner's earnings?

H. ☐ What was the petitioner's age at the time of the accident?

I. ☐ What was the petitioner's marital status at the time of the accident?

J. ☒ Were the medical services that were provided to petitioner reasonable and necessary?

K. ☒ What temporary benefits are due: ☒ TPD ☐ Maintenance ☒ TTD?

L. ☒ Should penalties or fees be imposed upon the respondent?

M. ☐ Is the respondent due any credit?

N. ☒ Prospective medical care?

FINDINGS

- On December 5, 2013, the respondent was operating under and subject to the provisions of the Act.
- On this date, an employee-employer relationship existed between the petitioner and respondent.
- On this date, the petitioner sustained injuries that arose out of and in the course of employment.
- Timely notice of this accident was given to the respondent.
- At the time of injury, the petitioner was 59 years of age, single with no children under 18.
- The parties agreed that the respondent paid $31,592.19 in temporary total disability benefits and $10,000.00 as an advance of permanency.

ORDER:

- The respondent shall pay the petitioner temporary total disability benefits of $820.80/week for 47-6/7 weeks, from December 6, 2013, through November 5, 2014, which is the period of temporary total disability for which compensation is payable. The respondent shall pay the petitioner temporary partial disability benefits of $7,132.67 for the period from August 16, 2015, through November 14, 2015. The respondent is entitled to offset of $41,592.19, the amount of benefits previously paid to the petitioner.
- The medical care rendered the petitioner was reasonable and necessary and is awarded. The respondent shall pay the medical bills in accordance with the Act, the medical fee schedule or any prior adjustments or negotiated rate. The respondent shall be given credit for any amount it paid toward the medical bills, including any amount paid within the provisions of Section 8(j) of the Act and shall hold the petitioner harmless for all the medical bills paid by its group health insurance carrier.
- The petitioner's average weekly wage was $1,231.20.
- The petitioner's request for penalties and fees is denied.

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

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

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

Robert E. Williams

Signature of Arbitrator

March 15, 2016

Date

MAR 15 2016

FINDINGS OF FACTS:

The petitioner, a left-handed concrete truck driver, injured his left shoulder on December 5, 2013, while lifting a chute on a concrete truck. He saw Dr. Thompson at Advocate Occupational Health for pain in the anterior and top of his shoulder. The doctor noted a full range of motion with pain at the end range of abduction and internal and external rotation. X-rays were negative. An MRI on January 8, 2014, noted a supraspinatus tendon tear, an infraspinatus tendon partial tear, a subscapularis tendon partial tear and a proximal biceps tendon tear.

Dr. Craig Cummins at Lake Cook Orthopedics saw the petitioner on January 21st and opined that the MRI revealed a supraspinatus rotator cuff tear, subacromial bursitis and a probable superior labral tear. His diagnosis was a rotator cuff tear and a probable SLAP tear for which he recommended surgery. On March 20th, Dr. Cummins performed a left shoulder arthroscopic debridement, acromioplasty, rotator cuff repair and open biceps tenodesis. He followed up with Dr. Cummins and received physical therapy at Diamond Physical Therapy from May 1st through September 23rd. He received work conditioning at Athletico from October 1st through the 29th, at which time it was noted that the petitioner had safely met all job requirements. Dr. Cummins gave the petitioner a twenty pound lifting restriction on September 24th. On November 5th, the petitioner reported little or no pain and a slight difficulty washing his back and lifting 10 pounds above his shoulders. Dr. Cummins opined that petitioner was at maximum medical improvement and released him to regular duty.

The new owners of the respondent's business, Ozinga, required a post-employment fitness evaluation in order for the petitioner to work for them. The petitioner

failed to complete dynamic lifting and job-specific testing due to problems with breathing and was not re-employed by Ozinga. An FCE by Athletico on April 14, 2015, indicated physical capabilities of the petitioner at the medium-demand level with a 40-pound lifting ability. The petitioner returned to Dr. Cummins on April 24th and reported improvement since his last visit and no difficulty reaching behind his back or overhead or sleeping on his left arm. The doctor recommended only work at the medium physical level up to 41 pounds.

FINDING REGARDING THE AMOUNT OF THE AVERAGE WEEKLY WAGE AND THE CURRENT EARNING CAPACITY:

The year prior to the petitioner's injury, the respondent paid him nine days of holiday pay and three forty-hour weeks of vacation pay at $30.78 per hour ($246.24/day and $1,231.20/week). The acceptance and payment of $1,231.20 for a forty-hour workweek is the best proof of the petitioner's average weekly wage. The petitioner's average weekly wage was $1,231.20.

It is noted that Petitioner's Exhibit 10 provides wage information for the petitioner from December 7, 2012, through November 29, 2013. The period is only for 51 weeks and there is no wage information provided for the 5-week period between January 4, 2013, and February 8, 2013, the 3-week period between February 16, 2013, and March 8, 2013, the 2-week period between April 6, 2013, and April 19, 2013, or the 1-week period between September 28, 2013, and October 4, 2013. The petitioner did not provide sufficient evidence that he was unable to work during those periods due to inclement weather or due to a State of Illinois contract arrangement.

FINDING REGARDING WHETHER THE MEDICAL SERVICES PROVIDED TO PETITIONER ARE REASONABLE AND NECESSARY:

The medical care rendered the petitioner for his left shoulder was reasonable and necessary and is awarded.

FINDING REGARDING THE AMOUNT OF COMPENSATION DUE FOR TEMPORARY TOTAL DISABILITY AND TEMPORARY PARTIAL DISABILITY:

On November 5, 2014, Dr. Cummins opined that the petitioner was at maximum medical improvement and released him to regular duty. The respondent shall pay the petitioner temporary total disability benefits of $820.80/week for 47-6/7 weeks, from December 6, 2013, through November 5, 2014, as provided in Section 8(b) of the Act, because the injuries sustained caused the disabling condition of the petitioner.

The petitioner failed to prove that he conducted a genuine job search after his release to full duty by Dr. Cummins on November 5, 2014. His job search log is inadequate and appears to include a contact prior to his release to work. The petitioner's request for temporary partial disability benefits prior to employment by Durham School Services on August 16, 2015, is denied.

The petitioner is entitled to temporary partial disability benefits while working part-time at Durham School Services and while continuing to search for suitable, full-time employment commensurate with his trucking skills, experience and prior salary range. The petitioner has not looked for full-time employment or a truck driving job that does not require lifting more than 41 pounds. He has not sought employment in the higher-paying jobs recommended by Lawrence Kahan as would be expected in order to maximize his income if he did not have an ulterior motive. The petitioner's gross pay through November 14, 2015, was $5,306.59. The respondent shall pay the petitioner

temporary partial disability benefits for the 13 weeks from August 16, 2015, through November 14, 2015, totaling $7,132.67 (66% of $1,231.20(13) minus $5,306.59). The petitioner's request for temporary partial disability benefits after November 16, 2016, is denied.

FINDING REGARDING PENALTIES AND FEES:

The petitioner failed to prove that he is entitled to §19(l) and §19(k) penalties and fees. The evidence was insufficient to establish that the respondent's delay in the payment of temporary total and partial disability benefits was without a good and just cause or that their conduct was vexatious and unreasonable. There was a genuine dispute regarding the issues of the average weekly wage and the temporary total and partial disability benefits rates and periods. The petitioner's request 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

Krystyna Wolska,

Petitioner,

vs.

NO: 13 WC 32063

Sunstar Americas, Inc.,

17IWCC0006

Respondent.

DECISION AND OPINION ON REVIEW

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

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

- Petitioner was a 60 year old employee of Respondent, who described her job as machine operator/packer. Petitioner had worked at Respondent for 24 years and in department 59 for the prior 10 years where she packed toothbrushes on the Zoho and Tirro lines. Prior to working in that department Petitioner testified that she was feeling good and she had no problems with her neck, shoulders, or hands. She packed in that department 8 hours per day; every 2 hours they would change stations. They changed at break times and she had two 10 minute breaks and a 20 minute lunch and they changed after each break. She worked for a week on one machine and then rotated to the other the next week. On any given day she worked one machine (at different stations). She indicated that the stations were the same, the packing was all the same but the end of the whole proceeding was a little bit different at the different stations. Petitioner testified that she created a diagram of

the machines she worked at and noted her handwriting and drawing on it. Petitioner viewed the diagrams in Petitioner's Exhibit 6 (PX6). She again indicated she created the drawings and the writing was all hers (Respondent objected as to foundation and accuracy). Petitioner created the diagrams 2-3 years before; after she had stopped working for Respondent (It had now been 3 years since Petitioner worked for Respondent). Petitioner testified that she created the drawings (at home, by herself) a few months after she stopped working at Respondent. She then sent the documents to her attorney. Petitioner testified she created the drawings based on the way she used to work as she had remembered. Petitioner testified that she did not take measurements to make the diagrams to scale; they are based on her memory. (Respondent again objected to the line of questioning regarding diagrams as she is not a machine expert and the drawings were not to scale. Petitioner's counsel stated the diagrams for visualization to generally understand what the job involved; not as occupational expert or ergonomic expert). (Respondent again made foundational objection). (Arb overruled objection pending addressing the issue later as an exhibit; used to tell what Petitioner did, as an aid to her testimony). She indicated the Zoho and Tirro machines look the same but sometimes the labels are changed. The product may be different as to how the workers work. She noted the machines are for packing. (Objection noted as kept on record, but overruled as to questioning here). Petitioner stated on the line they just packed whatever was on the line. Petitioner indicated that there were 3 work stations. She indicated at station 1 she was taking the brushes out of the box, facing the line. With her right hand she took the brushes out of the box from a shelf next to the line. The number of brushes varied per box and she grabbed many brushes at a time. With her other hand she was taking the different colors and putting them on the line, every brush she had to put in a different form. She indicated on one side of the line a person was putting 3 brushes and the other side the other person was placing 3 brushes into the slots; every slot had to have a brush placed. With her left hand she was taking the 3 colors and putting them on the line. There were the different colors and they could not be put together. She did not recall how many she had to place during a 2 hour rotation, but it was constant. She indicated there was a special paper on the machine that sealed through the brush and they would be cut off and the brushes transferred over and the last person at station 3 would check all the brushes to be sure they were okay. She again indicated that she was taking many tooth brushes off the shelf with her left hand and placing them onto the line in colors as needed. The brushes were close to her but above her. Petitioner stated that she placed the brushes into the machine slots with her right hand. She also helped with her left hand as the machine speed was very fast. Getting the brushes into the slots was harder as the brushes got bigger; more rubber on them. She indicated in the 2 hour station shifts her hands were going all the time. She indicated station 2 was basically a mirror image of station 1. Station 3 was the tooth brushes going through the sealer; like a packaging. She indicated the person at station 3 was taking 6 brushes and checking them and putting them to the bag of the machine. If there was a problem with the brushes they were just set aside. With one hand they would put the 6 brushes to the bag machine where they were sealed and with the other hand they would take the bag and put it into a box. She noted one box contained about 140 bags and she would fill 18-20 boxes in a 2 hour station segment. She indicated she was working both hands at the same time; the boxes were next to her. Petitioner testified that the speed of the machine was so fast and she could not follow

everything and sometimes the toothbrushes were falling down to the box and she had to pick them up from the box and put them in the bag machine. There were 3 people working the line so they had a lead operator who was helping to move them and they had to seal them and put them to the side. She indicated her hands were working all the time and she had to lift the boxes which she believed weighed over 20 pounds, heavier with the heavier tooth brushes. Petitioner indicated that she would do 18-20 boxes in the 2 hour station shifts. Petitioner stated that she would do 150 to 180 boxes a day, if that was the order. She indicated the boxes were heavy and her hands were hurting her as was her shoulders and arms. She testified the toothbrushes are light but the boxes are not and the gray boxes were heaviest at 18-20 pounds.

- Petitioner indicated that the Zoho machine was different; sometimes there were 3 on that and it was harder to perform the job on that machine. She indicated a person had to move the boxes from the skid by themselves with no help. On the Tirro machine they were able to get assistance. The type of work was similar on the Zoho machine but it was a harder job as she had to do everything herself. There was only the one person loading it. The person putting the brushes on the line also had to pack it and put it onto the skid. Petitioner testified the Zoho machine was faster; if there were complaints the speed was changed. Those boxes weighed 16-18 pounds. Petitioner testified to mostly working on the Zoho machine.

- Petitioner testified to operating the Alloyol machine 10 years before that. Petitioner testified that between 2010 and 2013 her hands were hurting her, especially her right hand, arm and back. She stated it was a sharp pain and she could not even sleep at night. She testified she had a problem when she slept, her right hand/arm was hurting her, and when she laid on her back, her back would hurt and it was hard for her to get up. Petitioner testified she was noticing the problem for a long time before she saw a doctor, but when it started being a sharp pain she went to see the doctor. Petitioner saw her family doctor, Dr. Bulava, in August 2013. Petitioner testified that when she went to the doctor she told her supervisor, Greg Dietrich, of the symptoms she was feeling. Petitioner testified she had talked to Greg more than one time; they had conversations at work, by the machine. Petitioner indicated there were other people there when she was talking to Greg. She indicated she talked to Greg within a few months of seeing her doctor. Petitioner agreed she only worked about another week after seeing Dr. Bulava; she then indicated she had reported it August 24. Petitioner agreed she went to Advocate Occupational Health Center in Niles on two occasions in August 2013. Petitioner stated that she got the address for and was sent to that clinic by Respondent. Petitioner followed up with Dr. Bulava a few times in 2013 and was given Ibuprofen, pain killers. Petitioner then began seeing Dr. Sokolowski, an orthopedic doctor, September 18, 2013 on referral from Dr. Bulava. Dr. Sokolowski treated Petitioner's hands, arm, and back. Petitioner had an MRI done of her right hand, right shoulder, and her lower back in October 2013. Petitioner testified Dr. Sokolowski never released her to return back to work. Petitioner did have some therapy (for right hand, arm, and back) but that only helped a short while. Petitioner testified when she saw Dr. Sokolowski on October 2015 he recommended an

epidural steroid injection and a functional capacity evaluation; she had not had those done. Petitioner testified she had not been paid any workers' compensation benefits.

- Petitioner saw Dr. Troy, at Respondent's carrier request, June 29, 2015. Petitioner testified at the time of hearing that her hands hurt her and she could not turn them, and she had problems getting dressed and combing her hair; she had to brush with her left hand. Petitioner stated that her right hand had been hurting her the most. She testified that it is a sharp pain. In regard to her back she stated it was bad and she had problems with standing and walking; she cannot stand for a long time and she has problems sitting. Petitioner testified she did not have the problems before she worked on those machines. Petitioner testified she had no prior accidents to those parts of her body and she had no new accidents to those parts of her body. Petitioner had not worked anywhere since she stopped working at Respondent in 2013. Petitioner testified that she was collecting disability. She had no other disability other than high blood pressure.

- Mr. Dietrich testified, for Respondent, that he had been with Respondent for 34 years and was working for Respondent in August 2013. Witness stated that he is assistant packing manager and in 2013 he believed he was packing and team leader. Mr. Dietrich testified that he was responsible for the operation of the packing area and all the employees within it. Mr. Dietrich testified that Petitioner had been one of his employees in August 2013 and he had known her as an employee of Respondent for several years; he had been Petitioner's direct supervisor. His interaction with Petitioner had been daily work assignments, putting her on the machine, some training responsibilities and things of that nature. He would align her on the machines. He stated they had a number of different packing machines and they worked different machines on different days based on company names. He does not work on the machines. He works the production floor going from machine to machine and observing what is going on with the machine and checking if things are going wrong. He checks the quality of product coming off the machines, the machine speeds, and if there are any mechanical issues. He makes sure the operators are in the positions they are supposed to be in. He works roughly 6:00am to 3:00pm, Monday through Friday, and occasionally Saturday. Mr. Dietrich testified in August 2013 Petitioner was a packing machine operator. He stated she loaded product into the machine, typically toothbrushes, dental floss, and things, and packaged products into blister packs they fill and seal. He stated the toothbrushes are made of polyprolylene handles (typically) with nylon bristles in them. He stated there are several varieties. The traditional brush is a single color and modern ones are either clear, or plastic with an inserted rubber type insert. He testified that the brushes weigh ounces; less than 5. Mr. Dietrich testified there are 2 basic types of machines that Petitioner operated. He stated one was a form, fill and seal machine that rolls flat plastic and runs through and forms the blister configuration, and the operator loads brushes into the cavities of the machine. Some have 6, some have 3 cavities. He stated the machine goes on and puts a backer on the product and it seals the backer, and it goes through a die cutting operation and comes out in individual packs at the other end. Mr. Dietrich testified the machine had 4 different position operators, 2 at the loading brushes into packing. He stated the operators take tooth brushes from boxes that are next to the machine and puts them into the open cavities. He stated they lift packages/boxes occasionally to put them onto the shelf they

are picking from. He stated they would reload the shelf about every 20 minutes; he stated there are 2 operators at the back of the machine taking the finished product off and inspecting and putting 6 or 12 brushes per bag and sealing the bag and putting those into a shipper and when full they seal it with tape and put it on a pallet. Mr. Dietrich stated on the form, fill, and seal line the boxes weigh 8-12 pounds; he noted their insurance company weighed them on several occasions so he knew the weights. He noted on the heat sealing packaging machine there are typically 4 people loading (blisters are pre-made). He stated one package is a travel set with various items and when loaded and sealed it gets ejected on to the conveyor and it was the same end process to put in a bag and seal the box for the shipper, and place the box onto a pallet. He stated the heaviest of those boxes weighs 18-22 pounds.

- Mr. Dietrich stated that their operators (Petitioner) rotate positions every 2 hours, so they would load for 2 hours, they would bag 2 hours, they would help at the back end for 2 hours; he stated they would not do any one position more than 2 hours at a time. He stated they take two 10 minute breaks; one morning and one afternoon, and they take a 20 minute lunch at noon. Mr. Dietrich identified RX 1, Ergonomic Job Analysis. Mr. Dietrich believed the analysis was from Travelers who had some time ago sent someone to detail the job; he indicated it was an accurate representation of Petitioner's job in August 2013. He indicated that the photos attached to RX 1 were as he had described the area machines, operations/stations and people in seated positions. He agreed Petitioner was not pictured there. He estimated the products seen boxed weighed about 10 pounds. Mr. Dietrich testified that Petitioner was not required to be at any one specific job position for 8 hours. He considered all the pictures shown as the cumulative job description. He indicated the only job outside the description was loading the brushes. He considered the job as moderately demanding; he did not consider it a demanding job. He indicated nothing on the report was inaccurate; it represented Petitioner's job duties in August 2013. Mr. Dietrich testified that as Petitioner's supervisor he was familiar with the process when an employee reports a work accident. He stated an employee is supposed to report the accident as soon as possible after it happens. He stated they then do an accident investigation report; he did not believe the form had been changed even now. He noted there is a portion for the employee to complete, a section for the investigation and for potential corrective actions, a section for witnesses. He stated they are all trained from their safety group as to the procedure. He noted they have group meetings and they meet in the mornings and discuss different things. It was noted Petitioner had an interpreter for hearing and Mr. Dietrich testified Petitioner had communicated with him at meetings in English so he understood she understood him. Mr. Dietrich testified that Petitioner never notified him of a work related incident in August 2013. He indicated they had filled out a report when she came in but he did not recall when she came to HR. He testified when she reported an accident she had been off work for an extended period of time and she came in to report she had been injured but he did not recall a specific date of injury. He stated Petitioner could have reported it to the HR group or any member of the management group, but he was unaware of her doing that (in August 2013). Mr. Dietrich testified there were no managers that came to him around August 21, 2013 saying she had reported an incident. Mr. Dietrich testified if an accident is reported they do have a clinic they ask the employee to go to; as part of their

investigation report; they normally provide transportation to that and to return. They had moved so he did not recall the name of the clinic (in Niles). He did not recall any transportation being provided to Petitioner for that.

In addition to the testimony, the Commission finds that Respondent presented the job analysis indicating the changing positions as per testimony. Respondent presented their §12 (IME) examiner's report indicating no causal connection other than to maybe a strain type injury. The treating records indicate causal connection opinions, but other than Petitioner's limited reporting of doing repetitive work, there is no indication that the doctors had a clear understanding of her job duties, and clearly no indication they were aware of the changing of job positions every 2 hours. Petitioner's testimony is less then compelling. Respondent's IME had the benefit of the job analysis for a more credible basis for opinion. The evidence and testimony finds that Petitioner failed to meet the burden of proving a repetitive trauma accident/injury that arose out of and in the course of her employment and failed to prove that her current condition of ill-being was causally related to any such repetitive trauma type injury. 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 no accident, and affirms and adopts the Arbitrator's finding as to no causal connection.

The Commission finds that Petitioner did not argue as to a period of benefits, only causal connection was addressed. There are records indicating restrictions or total off work authorizations from providers to then award benefits, however, the finding above of no accident, and no causal connection, renders the issue to deny any and all benefits moot. 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 denial of any and all total temporary disability.

The Commission finds that Petitioner did not argue as to medical expense benefits, only causal connection was addressed. There are records and bills from the various providers that would have supported an award, however, the finding above of no accident, and no causal connection, renders the issue to deny any and all benefits moot. 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 denial of medical expenses.

The Commission finds Petitioner did not argue as to permanent partial disability (PPD) benefits, only causal connection was addressed. Had the Commission found accident, and causal connection, there are records and her testimony to support an award of some PPD benefits (of a minimal strain type injury-no significant diagnosis other than degenerative in nature). However, the finding above of no accident and no causal connection renders the issue moot. 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 denial of any and all Permanent partial disability.

17IWCC0006

The Commission, however, finds that the Arbitrator's ruling rejecting Petitioner's exhibit 6 (diagram) was error. The rejection of the exhibit was, at worst, harmless error. The diagram really does not help given the preponderance of evidence and testimony of Respondent's witness rebutting Petitioner's testimony of the 'repetition', or lack thereof, of her work. Further, Petitioner noted weights which were not consistent, and not supported given the job analysis and Respondent witness' testimony.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 7, 2016 is hereby affirmed and adopted. (Any and all benefits denied (moot) with findings of no accident and no causal connection.)

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 13 2017
o-11/17/16
DLG/jsf
045

David S. Gore

Stephen Mathis

Mario Basurto

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WOLSKA, KRYSTYNA
Employee/Petitioner

Case# **13WC032063**

SUNSTAR AMERICAS
Employer/Respondent

17IWCC0006

On 6/7/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.43% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0293 KATZ FRIEDMAN EAGLE ET AL
DAVID BARISH
77 W WASHINGTON ST 20TH FL.
CHICAGO, IL 60602

0532 HOLECEK & ASSOCIATES
BARNALI ROY-MOHANTY
161 N CLARK ST SUITE 800
CHICAGO, IL 60601

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Krystyna Wolska
Employee/Petitioner

v.

Sunstar Americas
Employer/Respondent

Case # 13 WC 32063

Consolidated cases: n/a

17IWCC0006

An *Application for Adjustment 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 **4/20/2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **8/21/2013**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned **$24,835.20**; the average weekly wage was **$477.60**.

On the date of accident, Petitioner was **60** years of age, ***single*** with **0** dependent children.

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

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

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$5,076.88** for other benefits, for a total credit of **$5,076.88**.

Respondent is entitled to a credit of **$5,076.88** under Section 8(j) of the Act.

ORDER

Petitioner has not proven, by a preponderance of the evidence, that an accident occurred that arose out of and in the course of her employment by Respondent therefore, no benefits are awarded pursuant to the Act.

Respondent is entitled to a credit of $5,076.88 under Section 8(j) of the Act.

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

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

Findings of Fact

The petitioner had originally filed four (4) cases, i.e. 13 WC 32060; 13 WC 32061; 13 WC 32062; and 13 WC 32063. Petitioner made an oral motion, at the beginning of trial, to voluntarily dismiss the first three (3) cases, which was granted with no objection.

The disputed issues in 13 WC 32063 are: 1) accident; 2) notice; 3) causal connection; 4) medical bills; 5) temporary total disability; and 6) the nature and extent of Petitioner's injury. *See*, AX1.

Petitioner's testimony

Krystyna Wolska, ("Petitioner"), was employed by Sunstar Americas, ("Respondent"), in department 59. She had essentially performed the same jobs for twenty-four (24) years. She testified that she worked on two machines in the past ten years, i.e., the Zoho and Tirro machines. She had worked on an Alloyol machine prior to that time. All of these machines packed toothbrushes. The Alloyol packed kits that contained floss, a brush and toothpaste. Petitioner testified regarding her duties and how she worked on the Zoho and Tirro machines. She also provided self-drawn diagrams of her workstations and explained her diagrams as she testified. These diagrams were rejected by the Arbitrator when Petitioner offered them as evidence.

Petitioner testified that station 1 of the Tirro machine had boxes of individual toothbrushes that she picked up and placed on a tray. She would grab as many toothbrushes as she could hold in her right hand and using both hands, would put the brushes into slots on a line that was moving. She testified that she had to fill each slot and that her hands were moving very fast. She was flexing and extending her wrists and placing items with her left hand while grabbing the next group of brushes with her right. She had to match the color of the toothbrush with the color of the slot on the machine. Petitioner testified that she was sitting as she did this so the brushes were above her. She would switch when her hands became tired but being right-handed she mostly used her right hand. Each box held between 144 and 300 toothbrushes. She testified that she finished 18 to 20 boxes every two (2) hours and that the larger toothbrushes were more difficult to fit into the slots, on the moving line.

She did a similar job at station 2, testifying that she would twist her trunk as she used her right hand to place toothbrushes on the right side and use her left hand to take the bags out and put them into the boxes.

At station 3, she took brushes that had been individually packaged, grabbing six (6) at a time and dropping them into a bag. She sealed the bag and then put 140 bags into a box. According to the petitioner, she was grabbing brushes non-stop otherwise they would begin to fall on the floor. She was constantly turning as she dumped the brushes into the bags and the bags into boxes. Petitioner would fill 8 to 12 boxes per two-hour rotation. Petitioner testified that during a two-hour rotation, her hands would be moving at all times. She also testified that the speed of the machine was very fast and sometimes, she could not follow everything and toothbrushes would fall down into the box and

had to be picked up. Petitioner testified that the boxes could weigh up to twenty (20) pounds and that she had weighed boxes on a scale in the shipping area.

Petitioner testified that the Zoho machine was similar but more difficult for her, as there were only two (2) workers and less relief. She testified that she handled double the amount of toothbrushes on the Zoho and she worked that machine more often.

Upon cross-examination, Petitioner testified that she began noticing pain over the years and that she had sharp pain at night. She knew that the conditions in her right hand, arm, and shoulder were work-related. She testified that she had had these symptoms for a long time but continued to work. Other claims with earlier dates of accident were filed but dismissed before the hearing proceeded. Petitioner testified that she told her boss, Mr. Dietrich, about the pain she was developing in her hands, shoulders and back from working on the high speed machines. Mr. Dietrich denied receiving such notice. Petitioner presented to Advocate Occupational Health Center on August 27, 2013; six (6) days after the date of accident. Petitioner testified that her employer sent her there. Petitioner's Exhibit #4, the records from Advocate, show that the reports were being sent to Respondent. The record from Advocate on August 29, 2013 noted bilateral carpal tunnel syndrome, a right shoulder and lumbar strain. The Arbitrator notes that the petitioner applied for family and medical leave under the Family and Medical Leave Act, ("FMLA"), which was denied because her "medical provided indicates work related. FMLA does not cover work related injury". PX4.

X-rays of the lumbar spine were read to show subtle grade 1 spondylolisthesis at L5-S1 and anterior osteophyte formation at multiple levels. X-rays of the right shoulder showed no fractures or dislocations and mild degenerative changes involving the right AC joint. PX4.

Respondent's Witness

Mr. Gregory Dietrich, the assistant packaging manager, testified that he has worked for Respondent for 34 years. He confirmed the petitioner's description of the machines. He emphasized that the toothbrushes are very light; estimating the boxes of toothbrushes weighted 8-12 pounds. Mr. Dietrich explained that there was a 20 minute lunch and two 10 minute breaks and that the lines ran except for those times. Mr. Gregory Dietrich further testified that Petitioner's job included loading toothbrushes in the machines. The toothbrushes were made of polypropylene handles and nylon bristles and that a single toothbrush weighed a couple of ounces. Tr. pp. 82- 83.

Regarding the machines Petitioner would operate, he testified that there were four different operator positions or stations. There were two operator positions loading toothbrushes from a box into the package. Petitioner would be required to take toothbrushes out of boxes and place the brushes into a cavity. The remaining two operator positions would take the finished product off the machine, place the toothbrushes into bags and place the bags into boxes. Each bag held six (6) to twelve (12) toothbrushes. Each box weighed 8 to 12 pounds. Tr. pp. 84-85.

Operators rotated every two hours, so they would load for two hours and then bag for two hours. Operators did not stay in any one position for more than two hours at a time. Each eight-hour shift would produce 100 boxes. Accordingly, each two hour rotation would produce 25 boxes. While the weight of boxes could vary depending on the product, a box of bulk toothbrushes weighed 8.2 pounds. Regarding the two types of machines, i.e., Tirro and Zoho, the Tirro had a higher output than the Zoho but the Tirro would be staffed with more operators. Tr. pp. 87, 103-108.

Mr. Dietrich reviewed an ergonomic job description and testified that the document was an accurate description of Petitioner's job duties. In summary, the job description describes a step-by-step process of loading product on the machine; and bagging and boxing the finished product. Mr. Dietrich testified that the job would not be considered demanding. Lastly, Mr. Dietrich testified that he trains the employees regarding reporting accidents and that the petitioner did not notify him of an accident on the subject date however, a report was completed after she had been off work for an extended period of time. Tr. pp. 94-98.

Petitioner testified that she told her boss, Mr. Dietrich, about the pain she was developing in her hands, shoulders and back from working on the high speed machines. Mr. Dietrich denied receiving such notice. Petitioner was sent to Advocate Occupational Health Center on August 27, 2013, six (6) days after the date of accident. Petitioner testified that she went to this facility as her employer had sent her there. Petitioner's Exhibit 4, the records from Advocate, show that the reports were being sent to Respondent. The record from Advocate on August 29, 2013 showed that the petitioner was diagnosed as having bilateral carpal tunnel syndrome, a right shoulder strain and a lumbar strain.

Medical History

Petitioner initially testified that prior to working in department 59, she had no issues with her neck, shoulder and hands. However, upon cross-examination, she testified that she had problems with her right hand, arm and back on or about August 26, 2008, prior to the alleged date of accident. She believed that these problems were due to repetitive work.

She testified that she claimed a work-related back injury, on or about September 23, 2010; and problems with her right hand, arm and back, on or about September 10, 2011, prior to the alleged date of accident. She believed that these problems were due to repetitive work. She testified that she had knowledge that her right hand, arm and back conditions were related to repetitive work, since 2008. Tr. pp. 14, 56-59.

She testified that her right hand, arm and back began to hurt from 2010 to 2013 and that she would feel a sharp pain at night, while sleeping. Also, her back would hurt while laying on it and she had a problem getting up from bed, due to sharp pain in her arm. She testified that she was symptomatic for a "long time." Tr. pp. 42-43.

On August 12, 2013, Petitioner presented to her choice physician, Dr. Gregory Bulava, at Family Medicine and was diagnosed with DeQuervain's tenosynovitis and shoulder impingement syndrome.

On August 21, 2013, Dr. Bulava completed FMLA documents reflecting that her condition was "chronic with acute exacerbation work related repetitive movement injury," which began in May 2013. There is no indication that the doctor reviewed Petitioner's job description. PX1.

On August 26, 2013, Petitioner's request for FMLA was apparently denied because her "medical provider indicates work related. FMLA does not cover work related injuries". PX4.

On August 27, 2013, Petitioner was sent by Respondent to Advocate Occupational Health after being treated by her family doctor. She was diagnosed with right shoulder pain, right CTS and lumbar strain. The doctor did not review Petitioner's job description and the records do not reflect whether the conditions are related to her employment. PX4.

On September 16, 2013, Petitioner returned to Dr. Bulava and was diagnosed with degenerative disc disease of the lumbar spine and spondylolisthesis. There is no statement reflecting that the back condition is related to her employment. She was referred to Dr. Sokolowski for evaluation. PX1.

On September 18, 2013, Petitioner presented to Dr. Sokolowski and reported that she has a long history of working as a packing machine operator. She indicated that her duties included repetitive motion and frequent lifting of heavy boxes. She did not report a work-related injury. A job description was not reviewed. The doctor recommended MRI's of the right wrist, right shoulder and lumbar spine for further evaluation. PX2.

MRI's taken on October 9, 2013 demonstrated right wrist subcortical cyst at the ulnar aspect, minimal spurring; and signal changes to the carpal ulnaris, suggestive of tendinosis. MRI of the lumbar spine demonstrated minimal disc bulging through the lumbar spine without stenosis and L5-S1 facet arthrosis. MRI of the right shoulder demonstrated mild supraspinatus tendinosis, moderate subscapularis tendinosis, biceps tendinosis, impingement and AC joint arthrosis. PX2.

On November 1, 2013, Dr. Sokolowski opined that Petitioner's conditions were causally related to a work-related injury without review of a job description or details of Petitioner's job duties. The doctor recommended continued therapy, possible right shoulder and lumbar injections; and pain medication.

On April 7, 2014, Petitioner reported increased pain in the lumbar spine radiating down her lower extremities. Petitioner was diagnosed with work-related, bilateral, shoulder rotator cuff tendinitis, right wrist pain and lumbar pain, with radiculopathy. The doctor recommended continued therapy and lumbar ESI. PX2.

On February 13, 2015, Petitioner returned to Dr. Sokolowski and for the first time, gave a verbal, detailed description of her work duties. She reported that her duties included moving product on the production line, packaging toothbrushes in a repetitive fashion; and rotating positions after two hours to the end-line to pack and load boxes. She reported that she was required to repetitively lift, turn and pivot. She was required to carry and manipulate boxes weighing 17 to 21 pounds. She reported that she had been employed in this capacity for twenty-one (21) years. PX2.

On June 29, 2015, Petitioner presented to Respondent's Section 12 examination with Dr. Troy who had an opportunity to review complete medical records, a job analysis report and exam Petitioner for approximately one hour. Petitioner reported that on August 21, 2013, she was required to repetitively pick up small boxes weighing twenty (20) to thirty (30) pounds throughout the day. She would lift the boxes anywhere from 50 to 60 times per day. The doctor noted that "there appears to be a very appropriate ergonomic environment created in order to mobilize these boxes." Dr. Troy opined that her various physical conditions were related to degenerative processes rather than work. He thought that her condition was secondarily due to age and time affecting multiple body parts and not causally related to her employment. RX2.

On August 12, 2015, Petitioner returned to Dr. Sokolowski, who recommended a functional capacity evaluation, ("FCE"). Dr. Sokolowski reviewed the IME and questioned Dr. Troy's opinion that the conditions were degenerative in nature. Specifically, Dr. Sokolowski stated, "were that the case, the same degenerative changes would have been present on the day before the patient's reported injury as they were after the reported injury." As previously noted, Petitioner's primary doctor, Dr. Bulava, stated that Petitioner's conditions began in May 2013, prior the date of alleged accident and Petitioner testified that she was aware of her right hand, arm and back issues since 2008.

On October 26, 2015, Petitioner presented to Dr. Sokolowski for the last time. To date, Petitioner has not undergone a FCE.

Even though Petitioner has not worked since 2013, she testified that she currently has right hand, right arm and back pain. Her left hand also hurts but she is not claiming a left hand injury. She is right hand dominant and primarily uses her right hand for household chores. She has problems with standing and is currently collecting disability benefits. Tr. pp. 50-53; 70.

The respondent presented an ergonomic job analysis of the Petitioner job; with the objective being to determine it Petitioner's injuries should result in compensability. Under employment history, it states that the petitioner's length of time with the current employer and in the job, at the time of injury, is sixteen (16) years. The Arbitrator notes that the petitioner testified, in an unrebutted manner, that she has been working for this employer for twenty-four (24) years. The remainder of the analysis appears to show work actions supported by the testimonies of Petitioner and Mr. Dietrich. In summary, the Arbitrator reads this analysis to state that while there is minimal exposure to risk of

certain body parts, at certain times while working on the machines; and that there may be risk of exposure to those body parts at other times while working on the machines. RX1

Conclusions of Law

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

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

The burden is on the Petitioner seeking an award to prove by a preponderance of credible evidence all the elements of his claim, including the requirement that the injury complained of arose out of and in the course of his or her employment. *Martin v. Industrial Commission*, 91 Ill.2d 288, 63 Ill.Dec. 1, 437 N.E.2d 650 (1982). The mere existence of testimony does not require its acceptance. *Smith v. Industrial Commission*, 98 Ill.2d 20, 455 N.E.2d 86 (1983). To argue to the contrary would require that an award be entered or affirmed whenever a claimant testified to an injury no matter how much his testimony might be contradicted by the evidence, or how evident it might be that his story is a fabricated afterthought. *U.S. Steel v. Industrial Commission*, 8 Ill.2d 407, 134 N.E. 2d 307 (1956).

It is not enough that the petitioner is working when an injury is realized. The petitioner must show that the injury was due to some cause connected with the employment. *Board of Trustees of the University of Illinois v. Industrial Commission*, 44 Ill.2d 207, 214, 254 N.E.2d 522 (1969); see also *Hansel & Gretel Day Care Center v. Industrial Commission*, 215 Ill.App.3d 284, 574 N.E.2d 1244 (1991).

The Illinois Supreme Court has held that a claimant's testimony standing alone may be accepted for the purposes of determining whether an accident occurred. However, that testimony must be proved credible. *Caterpillar Tractor v. Industrial Commission*, 83 Ill.2d 213, 413 N.E.2d 740 (1980). In addition, a claimant's testimony must be considered with all the facts and circumstances that might not justify an award. *Neal v. Industrial Commission*, 141 Ill.App.3d 289, 490 N.E.2d 124 (1986). Uncorroborated testimony will support an award for benefits only if consideration of all facts and circumstances support the decision. *See generally, Gallentine v. Industrial Commission*, 147 Ill.Dec 353, 559 N.E.2d 526, 201 Ill.App.3d 880 (2nd Dist. 1990), *see* also *Seiber v. Industrial Commission*, 82 Ill.2d 87, 411 N.E.2d 249 (1980), *Caterpillar v. Industrial Commission*, 73 Ill.2d 311, 383 N.E.2d

220 (1978). It is the function of the Commission to judge the credibility of the witnesses and to resolve conflicts in the medical evidence, and assign weight to the witness' testimony. *O'Dette v. Industrial Commission*, 79 Ill.2d 249, 253, 403 N.E.2d 221, 223 (1980); *Hosteny v. Workers' Compensation Commission*, 397 Ill.App. 3d 665, 674 (2009).

As to repetitive trauma injuries, Petitioner has the burden to prove a specific incident traceable to a definite time, place and cause or a date on which the injury manifests itself. In determining a manifestation date, Petitioner must allege a date of accident which both the fact of the injury and the causal relationship of the injury to Petitioner's employment would have become plainly apparent to a reasonable person.

In the instant case, Petitioner testified that she became aware of her right hand, arm and back pain in 2008 and 2010 however; she did not notify Respondent at that time and continued to work in pain. The alleged accident date, i.e. August 21, 2013, is not supported by the Petitioner's initial medical records of Dr. Bulava because the petitioner apparently did not mention that the pain in her hands, shoulder and back was work-related. The Arbitrator concludes that Petitioner has not proven, by a preponderance of the evidence that an accident occurred, on August 21, 2013, which arose out of and in the course of her employment.

Based on the above and the evidence presented at trial, Petitioner has not proven, by a preponderance of the evidence, that an accident occurred that arose out of and in the course of her employment by Respondent therefore, no benefits are awarded. In that the petitioner has not proven an accident, the remaining issues are moot and will not be addressed.

17IWCC0006

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
13WC32063
SIGNATURE PAGE

Signature of Arbitrator

June 7, 2016
Date of Decision

JUN 7 - 2016

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

Scott Smith,

Petitioner,

17IWCC0007

vs. NO: 14 WC 32445

Pepsi,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 1, 2016 is hereby affirmed and adopted.

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

17IWCC0007

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 17 2017
KWL/vf
O-1/10/17
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

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

17IWCC0007

SMITH, SCOTT
Employee/Petitioner

Case# **14WC032445**

PEPSI
Employer/Respondent

On 3/1/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

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

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

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)

17IWCC0007

Scott Smith
Employee/Petitioner
v.

Pepsi
Employer/Respondent

Case # 14 WC 32445

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

DISPUTED ISSUES

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

B. ☐ Was there an employee-employer relationship?

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

D. ☐ What was the date of the accident?

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

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

G. ☐ What were Petitioner's earnings?

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

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

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

K. ☒ Is Petitioner entitled to any prospective medical care?

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

M. ☐ Should penalties or fees be imposed upon Respondent?

N. ☐ Is Respondent due any credit?

O. ☐ Other ____

17IWCC0007

FINDINGS

On the date of accident, August 1, 2014, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $60,445.32; the average weekly wage was $1,162.41.

On the date of accident, Petitioner was 44 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 $n/a for TTD, $n/a for TPD, $n/a for maintenance, and $n/a for other benefits, for a total credit of $n/a.

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

ORDER

Respondent shall authorize and pay for ongoing reasonable and related treatment, including the L4-S1 fusion with interbody cage and posterior instrumentation with laminectomies at L4 and L5 John Andreshak, MD, has recommended for Petitioner's lower back condition of ill-being, pursuant to Section 8 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.

Jessica A. Kluntz

Signature of Arbitrator

2/26/16

Date

ICArbDec19(b)

MAR 1 - 2016

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

SCOTT SMITH, Petitioner,	)	17IWCC0007
v.	)	Case No: 14 WC 32445
PEPSI CO., Respondent,	)	Geneva

ADDENDUM TO THE DECISION OF THE ARBITRATOR

This matter proceeded to hearing before the Arbitrator on January 11, 2016. The parties stipulated the issues in dispute were causal connection and prospective medical treatment. (Arb. 1)

The parties additionally stipulated, on the record, any temporary total disability or temporary partial disability was paid through the date of the hearing. The parties further stipulated, on the record, medical bills were not in dispute, as Respondent agreed to pay or had paid all the medical bills pursuant to the fee schedule and Section 8(a). (Id.)

Admissibility of Respondent's IME Report & Peer Review Reports

Prior to Petitioner's testimony, the parties addressed the admissibility of several proposed exhibits. Petitioner agreed to withdraw Petitioner's Exhibit 7, relating to medical bills, on the basis of the prior stipulation regarding the same.

Counsel for Respondent proffered Respondent's Exhibits 1-4. Respondent's Exhibits 1-3 were the Independent Medical Examination report and subsequent addendums authored by Frank Phillips, MD. Respondent's Exhibit 4 was a peer review report Dr. Phillips relied on in authoring his reports. Counsel for Respondent indicated he was aware counsel for Petitioner would object to the admission of Respondent's Exhibits 1-4 on the basis of hearsay. Counsel for Respondent then asked for a continuance to allow Respondent to depose both Dr. Phillips and Kenneth Kopacz, MD, the author of the peer review report. Counsel for Respondent asserted in September 2015, when counsel for Petitioner made Respondent aware he would object to the admission of the IME and peer review reports on the basis of hearsay, Respondent contacted Dr. Phillips to set up a deposition. However, counsel for Respondent was informed the first available date Dr. Phillips had for a deposition was late April 2016, seven months after Respondent's inquiry. Additionally, at the time of trial, Respondent could not provide any potential dates for depositions of either Dr. Phillips or Dr. Kopacz.

The Arbitrator determined Respondent's Exhibits 1-4 were not admissible on the basis of hearsay. The Arbitrator indicated she could think of no hearsay objection under which the IME reports or the peer review report would be admissible. The lack of admissibility of such documents due to hearsay concerns is precisely why depositions

of the report authors should have been conducted. The Arbitrator stated the matter should proceed, and Respondent's motion for a continuance was denied.

Respondent then made a motion for bifurcation, asking to conclude and close proofs once said depositions were completed. Petitioner objected, stating counsel for Petitioner made counsel for Respondent aware in September 2015 Petitioner would object to the reports on hearsay grounds. Petitioner asserted at no point did counsel for Petitioner refuse to cooperate with or claim to be unavailable for any deposition attempting to be scheduled. Moreover, Petitioner expressed concern that, even though Respondent knew the extend timeline for the deposition in September 2015, yet scheduled no deposition, Dr. Phillips's availability conceivably could now be July 2016 or beyond. As the 19(b) motion filed represents a motion for an emergency hearing, Petitioner asserted allowing the hearing to be delayed until an even later time did not comport with the meaning of an emergency motion pursuant to the Workers' Compensation Act.

The Arbitrator agreed with Petitioner, and, on the basis that the current hearing was on an emergency motion, denied Respondent's motion to bifurcate. Additionally, the Arbitrator reaffirmed her decision that Respondent's Exhibits 1-4 were not admissible, as their admission, with no hearsay exception, would be in contradiction of the Illinois Rules of Evidence.

Respondent then asked for a continuance until February or March 2016 to subpoena Dr. Phillips and Dr. Kopacz to personally appear to testify. The Arbitrator denied Respondent's motion.

Finally, Respondent asserted the Arbitrator's refusal to admit the IME report was a violation of Respondent's rights pursuant to Section 12 of the Act, as well as Respondent's due process rights. Respondent argued, as workers' compensation hearings are administrative in nature, compliance with the rules, while required, could be relaxed to effectuate the purposes of the act.

Petitioner asserted Petitioner also had due process rights that needed to be taken into consideration. As the intent of the Act is to provide expedited hearings for emergency motions, respondents conceivable could select a doctor who could never be available and delay hearings indefinitely on the basis of violations of their rights. While Petitioner recognized Respondent is entitled to certain rights under the Act, those rights must be exercised in a reasonable manner. And when balanced with the emergency nature of the hearing at hand, further delay would infringe on Petitioner's due process rights.

The Arbitrator agreed with Petitioner, and denied Respondent's motion for a continuance or bifurcation. The hearing then proceeded with testimony from Petitioner.

Petitioner's Testimony

Petitioner testified he had been a Pepsi employee for 25.5 years. For 17 of those years, Petitioner worked as a delivery driver. On a daily basis, Petitioner lifted multiple cases

of soda at a time, each weighing ten pounds per case, "bags in a box," or syrup for soda machines, each roughly 70-80 pounds, and CO_2 tanks weighing 70-80 pounds.

On August 1, 2014, Petitioner testified he was making a delivery to a BP on his route. Petitioner unloaded the truck, loading the product onto his hand cart, and began pulling the cart into the store. However, as Petitioner pulled the handcart through the doorway to the store, the door caught on the wheel of the handcart. As the handcart came to a sudden stop while Petitioner was still pulling, the abrupt stop caused Petitioner to twist back toward the cart. Petitioner immediately felt severe pain in his lower back, and the sharp pain was so significant it brought him to his knees.

Although the BP was Petitioner's first stop on his route that day, Petitioner immediately contacted him supervisor and indicated he would be unable to complete his route due to the immense pain in his back. After returning to the shop, Petitioner's supervisor instructed Petitioner to seek immediate medical treatment at Tyler Medical Center.

History of Medical Treatment

Robert Long, D.O., of Tyler Medical Center evaluated Petitioner on August 1, 2014. (PX6.) Petitioner provided Dr. Long with a history of injuring his back by a twisting motion when the dolly full of product he was maneuvering through the doorway caught and stopped abruptly. (PX6.) Petitioner indicated he previously experienced episodes of back pain, but had not sought treatment for any issues in more than a year and a half. (Id.) Examination of Petitioner's back revealed midline and paravertebral muscle tenderness with limited range of motion secondary to complaints of pain, particularly with forward flexion. (Id.) Additionally, Dr. Long noted spasms present.

X-rays performed Petitioner's lower back were negative for acute osseous pathology. (Id.) Dr. Long diagnosed Petitioner with a lumbar strain and lumbar spasms. (Id.) Dr. Long placed Petitioner on light duty with restrictions of no lifting, pushing, or pulling greater than 10 pounds, no stooping, bending, commercial driving, or reaching or lifting above shoulder level. (Id.)

Dr. Long re-evaluated Petitioner on August 4, 2014 noting his continued complaints of pain and tightness in his back. (PX6.) Examination again revealed tenderness to the midline and paravertebral muscles, although spasm was not present. (Id.) Range of motion was within normal limits, however, extension and side bending continue to produce complaints of pain. (Id.) Dr. Long continued Petitioner on light duty with restrictions increased to 15 pounds. (Id.)

Petitioner again presented to Tyler Medical Center on August 11, 2014. (Id.) At that time, Petitioner indicated when bending two days prior, he experienced a sudden onset of pain in his lumbar region. (PX6.) Petitioner stated he experienced no improvement since last evaluated. (Id.) Dr. Long continued Petitioner on light duty restrictions, and indicated Petitioner would follow up with John Andreshak, M.D., of OAD Orthopaedics. (Id.)

Petitioner presented for evaluation by Dr. Andreshak at Cadence Physician Group Orthopedics on August 27, 2014. (PX4.) Petitioner provided a history of pulling a cart filled with product through the door when his back twisted, causing Petitioner to experience a sudden onset of severe back pain. (Id.) Petitioner indicated he continued to experience increasing pain when driving and sitting, as well as tingling and pain radiating down his legs. (Id.) Examination of Petitioner's back revealed tenderness to palpation to the lumbosacral junction, as well as the left piriformis region. (Id.) Range of motion was limited by pain. (Id.) Straight leg raise for the left leg was positive at 90°. (Id.) Dr. Andreshak opined Petitioner likely had some disc herniation with possible degenerative disease causing mild stenosis, resulting in Petitioner's sciatica. (Id.) Dr. Andreshak diagnosed Petitioner with low back pain and lumbar sciatica, and ordered an MRI for additional diagnostic imaging. (Id.)

An MRI of Petitioner's lumbar spine was performed on September 11, 2014. (Id.) The results indicated Petitioner suffered from some degenerative disease with broad-based bulging at L5-S1. (Id.) L4 and L5 also showed central and left paracentral disc herniations with extrusion, as well as some minor degeneration at adjacent levels. (Id.) Dr. Andreshak's recommendation, after review of the MRI report, was a trial of epidural steroid injections at L4-L5. (Id.) Dr. Andreshak reevaluated Petitioner on September 24, 2014, at which time Petitioner indicated workers' compensation had not approved the epidural steroid injections. (Id.) Dr. Andreshak continued to recommend the epidural steroid injections, and diagnosed Petitioner with low back pain and a lumbar herniated nucleus pulposus. (Id.) Dr. Andreshak continued Petitioner on light duty. (Id.)

On October 23, 2014, James Wilson, MD of Interventional Pain Specialists, evaluated Petitioner for epidural steroid injections. (PX3.) Petitioner indicated he suffered from sharp, aching, and burning pain, as well as numbness. (Id.) Petitioner indicated lifting, walking, prolonged sitting, and driving aggravated his pain, and he additionally suffered from severe nighttime pain. (Id.) Examination revealed lumbar midline tenderness, as well as bilateral paraspinal tenderness. (Id.) Dr. Wilson opined, due to Petitioner's failure to experience relief from conservative therapy, an interventional procedure would be appropriate at this point to diminish Petitioner's pain. (Id.) Dr. Wilson then performed lumbar epidural steroid injections at L4-L5. (Id.)

As Petitioner did not gain extended relief from the initial epidural steroid injection and continued to experience discomfort and radicular pain, Dr. Andreshak recommended a 2nd epidural steroid injection at L4-L5. (Id.) This time, Dr. Andreshak recommended bilateral transforaminal injections due to Petitioner's foraminal stenosis. (Id.) Dr. Wilson performed this procedure on November 25, 2014. (Id.)

Dr. Andreshak re-evaluated the Petitioner on December 1, 2014. (PX3.) At that time, Petitioner indicated he initially experienced some improvement in pain, but the discomfort and radicular pain returned. (Id.) Dr. Andreshak recommended Petitioner undergo bilateral L5-S1 transforaminal epidural steroid injections due to his foraminal stenosis. (Id.) Dr. Wilson performed this procedure on December 16, 2014. (Id.)

On December 29, 2014, Dr. Andreshak re-evaluated Petitioner. (PX3.) Again, Petitioner indicated he had not experienced significant lasting relief from his most recent epidural steroid injection. (Id.) Dr. Andreshak opined, due to Petitioner's

failure to improve from conservative management, a discogram was indicated to evaluate the location of pain in his lumbar spine. (Id.) Dr. Andreshak indicated, based on his assumptions of what the discogram would reveal, he likely would recommend laminectomies of L4 and L5 with bilateral foraminotomies. (Id.) Additionally, Dr. Andreshak indicated, because of the mechanical/discogenic pain Petitioner experienced, it was his opinion the discogram should be performed in an effort to evaluate whether Petitioner would be a candidate for spinal fusion. (Id.)

Petitioner followed up with Dr. Andreshak on February 2, 2015, and March 4, 2015. (PX2.) The discogram recommended by Dr. Andreshak, had not been approved. (Id.) During that time, Dr. Andreshak continued to recommend a discogram to evaluate Petitioner's lumbar spine pain. (PX2.)

The discogram procedure was performed at Cadence Ambulatory Surgery Center on May 18, 2015. (PX8.) Dr. Andreshak reviewed the results with Petitioner on May 27, 2015. (PX1.) The discogram findings indicated concordant pain at L4-L5 and L5-S1, within normal control level at L3-L4. (Id.)

Based on Petitioner's continued back pain, the disc herniation at L4-L5, foraminal and subarticular stenosis at L5-S1, and degenerative disc disease at both levels, Dr. Andreshak opined Petitioner was a surgical candidate for L4 and L5 laminectomies, with an L4-S1 interbody cage fusion. (PX2.) Dr. Andreshak testified he recommended the fusion as well due to the fact that the surgery for the stenosis would take away some of the stabilization of the spine. (PX5, p.20.) Moreover, the mechanical back pain Petitioner suffered from would also be addressed by the fusion. (PX5, p.21.)

Dr. Andreshak further testified a discectomy alone would not be successful. (PX5, p.20.) A discectomy would address Petitioner's sciatic complaints. (PX5, p.20.) However, Dr. Andreshak stated a discectomy or laminectomy at L4-L5 with bilateral foraminotomies would not be an effective treatment in, as this procedure failed to address the mechanical aspect of Petitioner's back pain. (PX5, p.20, 39.) Should Dr. Andreshak proceed simply with the discectomy, Dr. Andreshak indicated Petitioner would fail to advance in physical therapy, which would necessitate a more complicated, less optimal fusion surgery at a later date. (PX5, p.20-21.) Dr. Andreshak opined the laminectomy and fusion surgery he recommended for Petitioner was necessary to resolve Petitioner's current state of ill health. (PX5, p.27.)

At the May 27, 2015 office visit, Petitioner elected to proceed with surgery. (PX2.) At trial, Petitioner testified he still desired the surgery Dr. Andreshak recommended to be performed, said that he would be able to return to work.

CONCLUSIONS OF LAW

The Arbitrator founds Petitioner presented at the hearing as honest and straight forward. The Arbitrator also finds Petitioner's testimony was consistent with the histories, treatment, and objective findings documented in the medical records, which were offered into evidence at the time of the hearing.

In support of the Arbitrator's determination Respondent's proffered Exhibits 1-4 are inadmissible, the Arbitrator makes the following conclusions:

The Arbitrator adopts her findings of fact and incorporates them herein by this reference.

The Arbitrator initially notes the Rules of Evidence apply to proceedings before the Commission. *Greaney v. Industrial Comm'n*, 358 Ill.App.3d 1002, 1010 (2005).

The Arbitrator addresses the inadmissibility in two parts. Under both analyses, the Arbitrator concludes Respondent's Exhibits 1-4 are inadmissible.

First, the Arbitrator determines, pursuant to the Illinois Rules of Evidence, the opinions contained in Respondent's Exhibits 1-4 are hearsay, as they are out of court statements offered to prove the truth of the matter asserted. A report from an independent medical examination and the opinions contained therein are hearsay, and are subject to exclusion on hearsay grounds. *Greaney*, 358 Ill.App.3d at 1011; *Alsaraj v. Taxi Affiliation Services, Inc.*, 14 IWCC 217, 4 (finding physician's IME report constitutes inadmissible hearsay where physician not made available for testimony at trial or by deposition). Therefore, in order for these exhibits to be admissible, they must fall under some exception to the hearsay rule.

A physician authoring an independent medical examination report is not an agent of the party hiring the physician, and therefore, statements made by the physician cannot be considered admissions of the hiring party. *Westin Hotel v. Industrial Comm'n*, 372 Ill.App.3d 527, 536-537 (2007); *Taylor v. Kohli*, 162 Ill.2d 91, 96 (1994). Moreover, an independent medical examination report is drafted in anticipation of litigation, rather than in the ordinary course of business, so it does not fall under the business records exception. *See, e.g., Fencl-Tufo Chevrolet, Inc. v. Industrial Comm'n*, 169 Ill. App.3d 510, 514 (1988). Additionally, Respondent's Exhibit 3, an addendum report drafted by Dr. Phillips, presents a double hearsay problem, as Dr. Phillips relied on the hearsay statement contained in the peer review report, Respondent's Exhibit 4.

The Arbitrator is not aware of, not did Respondent argue, any other exception to the hearsay rule which would permit the introduction of Respondent's Exhibits 1-4. Therefore, on the basis of hearsay without any exception, the Arbitrator determines Respondent's Exhibits 1-4 are inadmissible.

Second, the Arbitrator determines Respondent's due process rights are not violated by the exclusion of Respondent's Exhibits 1-4. "Due process includes the right to present evidence and argument in one's own behalf, a right to cross-examine adverse witnesses, and impartiality in rulings upon the evidence that is offered." *RG Construction Services v. Illinois Workers' Compensation Comm'n*, 2014 IL App (1st) 132137WC, ¶ 34, *citing W.B. Olson, Inc. v. Illinois Workers' Compensation Comm'n*, 2012 IL App (1st) 113129WC, ¶ 49. The Arbitrator agrees, pursuant to Section 12 of the Act, Respondent is permitted to have Petitioner examined by its own doctor, and that doctor's opinions may be presented at trial. However, the Arbitrator points out simply because Section 12 permits an IME to be conducted and a report drafted in response, nowhere in the statute is Respondent given unrestricted freedom to introduce such a report as evidence over Petitioner's hearsay objections. Respondent

is entitled to exercise its rights under Section 12 and offer that report as evidence at trial, if Respondent followed the proper procedures prescribed by the Act in order for the report to be admissible, namely allowing Petitioner to cross-examine the author regarding the opinions contained therein, either by deposition or at trial.

Here, Respondent has not made available either Dr. Phillips or Dr. Kopacz for cross-examination by Petitioner. The Arbitrator understands some of the difficulty in scheduling such depositions derives from the physicians' schedules. However, the Arbitrator would be remiss to fail to point out, even when Respondent became aware Petitioner would object to the reports on hearsay grounds in September 2015, and Respondent was informed at that time Dr. Phillips would first be available in late April 2016, Respondent made no effort to schedule any such depositions. Although Dr. Phillips's schedule certainly presents problems, Respondent failed to take any further action to secure Dr. Phillips's availability for testimony, even when faced with the knowledge Petitioner would object to the report on hearsay grounds. Respondent could have sought to compel the physicians' testimony by issuance of a dedimus potestatem pursuant to Section 16 of the Act.

The Arbitrator finds Respondent cannot claim a violation of its due process rights, when the alleged violation stems from Respondent's failure to take any action after September 2015 to provide for the testimony of the physicians authoring the reports Respondent intended to rely on at trial. The doctrine of unclean hands does not permit a party to benefit from its own wrongs. *Townsend v. Fassbinder*, 372 Ill.App.3d 890, 902 (2007), *citing Long v. Kemper Life Insurance Co.*, 196 Ill.App.3d 216, 219 (1990). Therefore, the Arbitrator concludes Respondent cannot assert a violation of its due process rights when its own conduct is what placed Respondent in its current position.

Moreover, the Arbitrator notes Petitioner's due process rights would be impaired should the Arbitrator permit the inclusion of Respondent's Exhibits 1-4. A party asserting a violation of its due process rights must be able to demonstrate the party is prejudiced by the conduct it asserts constitutes such a violation. *RG Construction Services*, 2014 IL App (1st) 132137WC, ¶ 34. Counsel for Petitioner asserted Petitioner's treating physician recommended surgery in May 2015. As the instant hearing occurred in January 2016, eight months after the surgery recommendation, to delay any further decision would only serve to prolong Petitioner's in-limbo status as he awaits approval of the surgery. Presuming the same timeline, and Respondent was again advised Dr. Phillips's deposition could first be scheduled seven months from the time of inquiry, said deposition would likely occur in August 2016. Dr. Andreshak recommended the L4-S1 fusion with laminectomies at L4 and L5 in May 2015. The instant hearing occurred January 12, 2016. Should the deposition take place in August 2016, that deposition would occur more than 15 months after Dr. Andreshak prescribed the surgery. Particularly when Respondent was aware of the necessity of the deposition testimony, and the delay in no way is at the fault of Petitioner, it would be unreasonable to permit such a delay when the issue arises on an emergency hearing.

Furthermore, admission of Respondent's Exhibits 1-4 would deprive Petitioner the ability to cross-examine both Dr. Phillips and Dr. Kopacz, clearly violating Petitioner's due process rights. This, coupled with the fact that counsel for Petitioner indicated, in

September 2015, Petitioner would object to the admissibility of these reports, leaves the Arbitrator unpersuaded Respondent's due process rights suffered any violation. However, admitting the reports or permitting another potentially significant delay to allow Respondent to depose the physicians, clearly violates Petitioner's due process rights and contravenes the fundamental purpose of the Act with regards to emergency hearings: expediency.

Therefore, based on the above, the Arbitrator determines Respondent's Exhibits 1-4 are properly excluded. The Arbitrator concludes these exhibits constitute hearsay for which no exception is available, and Respondent suffers no violation of its due process rights by exclusion of the exhibits.

In support of the Arbitrator's decision relating to "F," Whether Petitioner's current condition of ill-being is causally related to the accident, the Arbitrator makes the following conclusions:

The Arbitrator adopts her findings of fact and incorporates them herein by this reference.

The Arbitrator finds Petitioner's current condition of ill-being is causally related to the accident. It is undisputed Petitioner suffered a work-related accident, injuring his lower back, on August 1, 2014. Petitioner testified he previously experienced episodes of lower back pain, for which he occasionally received treatment at the clinic. However, Petitioner was not suffering from any back injury, nor being treated for any back injury, at the time of the August 1, 2014 accident. Moreover, Petitioner testified his prior back injuries were insignificant as compared to his current condition, as he was never prescribed an MRI, let alone surgery, for his back.

Petitioner's testimony is consistent with the medical records submitted into evidence. Petitioner noted an immediate onset of sharp pain in his back when twisting after the handcart caught in the door in the midst of a delivery. Petitioner provided consistent histories and complaints to his treating physicians. Respondent offered no medical opinion to contradict Petitioner's testimony. Therefore, based on the foregoing, the Arbitrator determines Petitioner's current condition of ill-being is causally related to his August 1, 2014 workplace accident.

In support of the Arbitrator's decision relating to "K," whether Petitioner is entitled to any prospective medical care, the Arbitrator makes the following conclusions:

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.

Having found Petitioner's current condition of ill-being is causally related to Petitioner's lower back injury occurring August 1, 2014, the Arbitrator finds Respondent shall pay all reasonable and necessary medical expenses related to Petitioner's lower back injury. Based on Petitioner's course of treatment and the May 18, 2015 discogram results, Petitioner's treating physician, Dr. Andreshak, is

recommending an L4-S1 fusion with interbody cage and posterior instrumentation, and laminectomies at L4 and L5. Respondent presented no credible evidence this procedure would be an inappropriate course of treatment for Petitioner's condition. The Arbitrator therefore determines Petitioner is entitled to prospective medical care, including the surgery recommended by Dr. Andreshak, as well as any other reasonable treatment related to Petitioner's lower back injury sustained in the work-related accident on August 1, 2014.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
SANGAMON

☒ 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

Michael Wood,
Petitioner,

17IWCC0008

vs.

NO: 12 WC 28840

Centre Crown Mining, LLC,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 10, 2016 is hereby affirmed and adopted.

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

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

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

DATED: JAN 17 2017
KWL/vf
11/29/16
42

Kevin W. Lamborn

Michael J. Brennan

17IWCC0008

DISSENT

The evidence shows that Petitioner suffers from a pulmonary disease, namely simple CWP, based on the opinions of Dr. Paul and b-reader Dr. Smith. Dr. Paul testified that CWP is a progressive and incurable disease. He also opined that Petitioner had CWP to some degree when he left mining, and that his CWP was caused by the coal mine environment and coal dust inhalation. In support of this finding, the evidence shows that Petitioner worked in the coal mining industry for 29 years, all of it underground and involving exposure to coal, rock and silica dust as well as glue fumes. In addition, the record reveals that Petitioner continued to be actively exposed to this hazard right up until the date of his retirement on 4/3/09, and that since that time he has experienced partial impairment or disablement in the functioning of his body in the form of difficulty breathing while walking. As a result, I would reverse the Arbitrator and find that Petitioner proved by a preponderance of the credible evidence that he suffers from an occupational disease that arose out of and in the course of his employment with Respondent as of 4/3/09.

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

17IWCC0008

WOOD, MICHAEL
Employee/Petitioner

Case# **12WC028840**

CENTRE CROWN MINING LLC
Employer/Respondent

On 2/10/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.42% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0755 CULLEY & WISSORE
KIRK CAPONI
300 SMALL ST SUITE 3
HARRISBURG, IL 62946

1662 CRAIG & CRAIG LLC
CRAIG F WERTS
115 N 7TH ST PO BOX 1545
MT VERNON, IL 62864

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

17IWCC0008

MICHAEL WOOD
Employee/Petitioner

v.

CENTRE CROWN MINING, LLC
Employer/Respondent

Case # **12** WC **28840**

Consolidated cases: **n/a**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **DOUGLAS S. STEFFENSON**, Arbitrator of the Commission, in the city of **Springfield**, on **December 16, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☐ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☐ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☐ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☒ Other **Sections 1(d)-(f) and 6 of the Occupational Diseases Act**

FINDINGS

On **April 3, 2009**, Respondent *was* operating under and subject to the provisions of the Act.

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

On this date, Petitioner *did 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 **$48,425.76**; the average weekly wage was **$1,252.28**.

On the date of accident, Petitioner was **55** years of age, *married* with **0** dependent children.

Petitioner claims no medical bills.

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

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

February 10, 2016
Date

FEB 10 2016

17IWCC0008

MICHAEL WOOD V. CENTRE CROWN MINING, LLC

12 WC 28840

FINDINGS OF FACT AND CONCLUSIONS OF LAW

INTRODUCTION

This matter was tried before Arbitrator Steffenson in Springfield on December 16, 2015.

FINDINGS OF FACT

The parties submitted a Request for Hearing form that was marked as Arbitrator's Exhibit 1 and admitted into evidence. It noted the Petitioner had an average weekly wage of $1,252.28, was 55 years old at the time of injury, was married and had no dependent children. The parties also agreed the Petitioner was not claiming any unpaid medical bills. Furthermore, the parties agreed the Petitioner was not seeking any TTD, TPD, and/or maintenance benefits. The issues in dispute were disease, causation, and Sections 1(d)-(f) and 6 of the Occupational Diseases Act. Finally, the parties stipulated to receipt of this Arbitration Decision, and any subsequent Decision and Opinion on Review, via e-mail. (Arbitrator's Exhibit 1).

Petitioner, a 68 year old resident of Litchfield, is a high school graduate and United States Navy veteran. He worked for 27 years in coal mines, with all of those years being underground. In addition to coal dust, Petitioner was exposed to silica dust, rock dust and roof bolting glue fumes. Petitioner's last day of work in a coal mine was April 3, 2009. He was working at Respondent's Farmersville mine and was 62 years old on that date. His job classification was that of a shuttle car operator. Petitioner testified that he was exposed to coal dust on that day. Petitioner testified that he had filed for retirement and Social Security and just picked that day to get out. Petitioner has not worked anywhere else since his retirement date.

Petitioner started his mining career in May 1977 with Consolidation Coal in Coffeen, Illinois. For the first six months, Petitioner was a general laborer. He would set timbers, clean up belt lines and do anything else they needed that did not include work at the "face", where the coal is being mined. As a "timberman", the Petitioner would assemble wooden planks or posts to secure the escape routes. He also was responsible for cleaning areas of the beltline with coal dust accumulations. He testified that although the beltline was equipped with water sprayers, coal dust still would circulate around the beltline. He then went to the classification of belt repairman. In that job they extended the belt towards the face as the unit was moving in

and retracted it as the unit was retreating. After doing that job for a year and a half he had a job as a tubing man. Petitioner testified that as the continuous miner was going in to cut out the face, there was an exhaust fan and they would run the tubing into the miner and suck the dust out and send it down the return airline.

Petitioner testified that he left Consolidation in 1981 and went to work for Freeman which eventually became Respondent. He worked at the Farmersville mine from the time he started in 1981 until he left in 2009. Petitioner hired in at Respondent as a laborer. In addition to the jobs described earlier, he also ran a shuttle car and a roof bolter, which drills a hole in the ceiling of the mine to put in a support. He used glue to help spin in and secure the support in the roof. Petitioner testified that the roof bolting machines had a suction system on them to suck the dust into the holding tanks of the roof bolting machines. On occasion the system would plug up and dust would come shooting out of the hole. Petitioner testified that the epoxy glue used for the roof bolting would give off an odor. Petitioner worked as a mine examiner for a year or two. In that position he would examine all of the faces and escape routes and check for gases and dangerous conditions before each shift went underground. His final job at the mine was as a shuttle car operator. He did that for the last five or six years. The shuttle car hauls the coal from where it is being cut out of the face by the continuous miner to the belt so it can be taken out of the mine. Petitioner testified that there was a lot of dust with that job.

Petitioner first noticed breathing problems when he was going to and from his barn which is about 100 yards from the house. He could not walk the distance without stopping or without breathing heavily by the time he got back. Since he first noticed his breathing problems, they have stayed about the same. Petitioner testified that he walks with his wife a mile three times a week. They limit themselves to one mile because he has an artificial hip, and she has an artificial knee. He testified that he breathed heavily about the last quarter mile. He can climb 15 to 20 stairs before having to stop. Petitioner is not taking any breathing medications. He testified that his breathing does not affect his daily activities a whole lot. He testified that he has not hunted birds for the last eight or ten years due to the lack of birds, but he did not think he could go on a hunt at present and hunt all day like he used to because he does not have the physical ability to do so. Petitioner has never smoked. Petitioner has a large prostate, high cholesterol and high blood pressure which are all under control with medication. He had a foot of his colon removed in 2007 due to diverticulitis. He had a hip replacement in 2011.

Petitioner testified that the bottom of the mine is where the cage takes the miners underground. The face of the mine is where the block of coal is actually being cut out. There may be several miles between the bottom of the mine and the face. He described a unit as any

place where they have a miner running. In a unit there would be two roof bolters, two miner operators, a utility man, repairman, boss and two to three shuttle car operators so there were nine to eleven men working on a unit. Petitioner testified that the main line belts run anywhere from 48 to 60 inches wide. The unit belts usually run about 36 inches. The unit belt dumps the coal onto the main line belt which takes it out of the mine. When Petitioner used the term eight foot pins he was referring to the roof bolts which look like rebar.

On April 3, 2009, Petitioner signed a resignation from the mine. He testified that when he signed that resignation, he severed all his rights to employment with Respondent. From time to time while he worked as a coal miner, Petitioner underwent chest x-ray screening by NIOSH for black lung. After the chest x-ray was performed, they would send him an interpretation of the film. Petitioner did not bring any of those reports with him to arbitration.

Petitioner testified that he has never been a farmer as far as crop farming. He has horses and goes to the barn every day to feed his animals. He has to buy his hay and grain. He owns 17 acres which is pasture and timber. Petitioner is president of the Illinois State Horseshoe Pitchers Association. He testified that he pitches horseshoes once a week through the winter. He also does some woodwork including making Christmas ornaments. Petitioner and his wife country dance. They go to class once a week and there is usually a dance every other week. Petitioner and his wife also camp in their fifth wheeler.

Petitioner was examined by Dr. Glennon Paul on November 20, 2012, at the request of Petitioner's counsel. (Petitioner's Exhibit 1, Deposition Exhibit 2). Dr. Paul is board certified in asthma, allergy and immunology. (Petitioner's Exhibit (*hereinafter*, PX) 1, p. 9). Dr. Paul testified that when he did his fellowship in 1970 to 1972, there were not any pulmonary fellowships developed. He testified that during his fellowship he was responsible for pulmonary diseases. (PX 1, p. 10). Dr. Paul testified that he reads 100 chest x-rays a week and interprets the same number of pulmonary function tests. (PX 1, pp. 7-8). Dr. Paul testified that he has treated coal miners for coal mining induced lung disease since the 1970s. (PX 1, p. 8). Dr. Paul is not an A or B-reader. He is not board certified in pulmonary medicine. (PX 1, p. 46).

Dr. Paul testified that Petitioner reported coughing from time to time. It was not a considerable amount, but it was more than normal. On Petitioner's pulmonary function tests, Dr. Paul found mild restrictive disease. Petitioner's diffusing capacity was moderately decreased. In a never smoker, the reduced diffusing capacity was likely related to his black lung disease. Dr. Paul testified that Petitioner had pulmonary fibrosis probably with restriction of the lungs and decreased transfer of gases across the alveoli capillary membrane. (PX 1, pp. 12-13).

On the chest x-ray, Dr. Paul found fibronodular lesions throughout both lung fields. He testified that the fibronodular lesions were the cause of Petitioner's abnormal pulmonary function studies. Dr. Paul found the chest x-ray to be positive for coal workers' pneumoconiosis. (PX 1, p. 13). Dr. Paul testified that if the person has a negative chest x-ray that will not rule out that he could have pneumoconiosis. Pneumoconiosis may be found by a pulmonary function study, physical examination or biopsy that is not found radiographically. (PX 1, pp. 13-14). Dr. Paul testified that based on all of the data that he had on Petitioner, it was his opinion that Petitioner had coal workers' pneumoconiosis caused by the coal mine environment and coal dust inhalation. He testified that Petitioner had this pneumoconiosis at least to some degree when he left mining. (PX 1, pp. 15-16). Dr. Paul testified that based on his diagnosis of coal workers' pneumoconiosis, Petitioner could not have any further exposure to the environment of a coal mine without endangering his health. (PX 1, p. 16). Dr. Paul testified that based on Petitioner's restrictive lung disease and reduced carbon monoxide diffusing capacity, he could not have any further exposure to the environment of the coal mine without endangering his health. Dr. Paul also testified that in light of his cough Petitioner would be at risk to his health if he returned to the environment of a coal mine. (PX 1, p. 16). Dr. Paul testified that Petitioner is permanently medically precluded from working as a coal miner. (PX 1, pp. 17-18).

Dr. Paul testified that in order to have pneumoconiosis one must have, in addition to coal mine dust deposited in his lungs, a tissue reaction to it. That tissue reaction can be called scarring or fibrosis. Dr. Paul testified that the scarring of coal workers' pneumoconiosis cannot perform the function of normal healthy lung tissue. Dr. Paul testified that by definition, if one has coal workers' pneumoconiosis, he would necessarily have some impairment in the function of the lung at the site of the scarring whether it can be measured by spirometry or not. (PX 1, pp. 18-19).

Dr. Paul testified that Petitioner complained of dyspnea on exertion. He testified that there are many causes for that. Petitioner was not taking any breathing medications and did not relate a past history of having taken a breathing medication. (PX 1, p. 43). Petitioner did not tell Dr. Paul why he left the coal mine. Dr. Paul's examination of Petitioner's chest was normal. There were no signs of pulmonary disease on physical exam. Dr. Paul did not know what Petitioner's inspiratory volume was for the tracer gas as compared to his largest vital capacity in his diffusion capacity testing. (PX 1, pp. 43-44). Dr. Paul testified that more likely than not simple pneumoconiosis will not progress once the exposure ceases. (PX 1, p. 45). Dr. Paul testified that the type of opacity on the film was a "coal dust" opacity. He testified that when there is a round opacity, they coalesce and become an oblong one and when round opacities coalesce with two other round ones, it might be a square one. He did not give the film he interpreted a profusion rating as he did not measure the concentration of small

opacities in the affected zones of the lungs. He testified that they were just all over the place. (PX 1, pp. 45-46).

Dr. Henry K. Smith, board certified radiologist and B-reader, interpreted a chest x-ray dated March 7, 2012, as positive for pneumoconiosis, profusion 1/0 with P/S small opacities in the bilateral middle and lower lung zones. Dr. Smith also interpreted a CT scan dated May 12, 2008. On the CT scan he noted findings of coal workers' pneumoconiosis with interstitial fibrosis/small opacities primary P, secondary P, with all lung zones involved of profusion 1/0 to 1/1. (PX 2).

Records from NIOSH were admitted into evidence. Petitioner underwent NIOSH x-ray screening on April 14, 1977. Said chest x-ray was read by an A-reader and B-reader to be completely negative. (Respondent's Exhibit 3, pp. 2-3). A chest x-ray of August 22, 1984, was read by an A-reader and a B-reader as being completely negative. (Respondent's Exhibit (*hereinafter*, RX) 3, pp. 4-5). Petitioner underwent another chest x-ray on February 29, 1996, which was read by two B-readers as completely negative. A chest x-ray of August 21, 2000, was interpreted by one B-reader as completely negative. Another B-reader interpreted the same chest x-ray as negative for pneumoconiosis, profusion 0/1 with T/T opacities in all lung zones. (RX 3, pp. 8-9). A chest x-ray of September 7, 2005, was interpreted by two B-readers as not having any parenchymal or pleural abnormalities consistent with pneumoconiosis. (RX 3, pp. 10-11). A chest x-ray of May 8, 2007, was interpreted by two B-readers as not having any abnormalities consistent with pneumoconiosis. (RX 3, pp. 12-13).

At the request of counsel for Respondent, Dr. Cristopher A. Meyer reviewed Petitioner's chest x-rays dated May 8, 2007, February 16, 2012, and March 7, 2012. Dr. Meyer also reviewed chest CT scans dated May 12, 2008, and November 6, 2008. The 2007 film was a quality 3 due to underexposure with poor contrast. The February 2012, chest x-ray was quality 2 due to underinflation. The chest x-ray of March 2012, was quality 2 due to poor contrast and some mottle. All the films were of diagnostic quality. (RX 1, pp. 40-41). Dr. Meyer testified that the chest x-ray from May 2007, was normal, and there were no findings of coal workers' pneumoconiosis. The chest CT scan of May 12, 2008, showed a right lower lobe calcified granuloma and a four millimeter left lower lobe non-calcified nodule. There were calcified hilar and subcarinal lymphnodes which also are consistent with granulomatous disease. (RX 1, p. 44). The CT scan of November 6, 2008, was essentially identical to the one from May. On the chest x-ray of February 16, 2012, the lungs were essentially clear. There were no findings of coal workers' pneumoconiosis. (RX 1, p. 44). With regard to the examination of March 2012, the lungs were essentially clear. There was no lymphadenopathy and no findings of coal workers' pneumoconiosis. (RX 1, pp. 44-45). Dr. Meyer also reviewed the radiologists'

interpretations for the two CT scans. These reports were essentially the same as Dr. Meyer's interpretation. (RX 1, pp. 46-49).

Dr. Meyer has been board certified in radiology since 1992. (RX 1, p. 7). Dr. Myer has been a B-reader since 1999. (RX 1, p. 19). Dr. Meyer was asked to take the B-reading exam by Dr. Jerome Wiot who was on the original committee that designed the training course which is called the B-reader program. (RX 1, pp. 19-21). Dr. Meyer testified that radiologists have a 10% higher pass rate on the B-reading exam than other specialties. In Dr. Meyer's opinion radiologists have a better sense of what the variation of normal is. (RX 1, pp. 34-35). Dr. Meyer testified that in an average week he reads between 200 and 250 chest x-rays and 20 to 40 chest CT scans. (RX 1, p. 15).

Dr. Meyer testified that a B-reading is actually an epidemiologic evaluation of chest x-rays. A B-reader describes the quality of the film. There is a very specific form that has been developed that the B-reader goes through to evaluate the chest x-ray for the presence or absence of occupational lung disease. First, the B-reader evaluates the quality of the film, describes any limitations of the x-ray and then goes on to classify any parenchymal abnormalities. The B-reader decides whether there are any small nodular opacities or any linear opacities, and based on the size and the appearance of the small opacities, they are given a letter score. (RX 1, p. 22). Dr. Meyer testified that the B-reader also describes the distribution of the findings. Different pneumoconioses are seen in different regions of the lung so it is important to describe where the findings are in the lungs. He testified that coal workers' pneumoconiosis is typically an upper zone predominant process. (RX 1, pp. 22-23). Dr. Meyer testified that specific occupational lung diseases are described by specific opacity types. He testified that coal workers' pneumoconiosis is characteristically described by small round opacities. (RX 1, pp. 28-29). The last component of the interpretation is the extent of the lung involvement or the so-called profusion. (RX 1, p. 23). Dr. Meyer testified that the profusion defines the density of the small opacities in the lung. (RX 1, p. 30). Dr. Meyer testified that mottle can make the film look grainy and can simulate small opacities. He testified that underexposure of the film tends to accentuate the pulmonary vasculature and the reader has to be careful to not mistake that for a nodule or an opacity. (RX 1, pp. 27-28). Dr. Meyer testified that the other thing that can accentuate the vasculature is if the patient does not take a deep enough breath. (RX 1, p. 28).

Dr. Meyer testified that to become a B-reader one takes a weekend course which includes a series of lectures describing the B-reading classification system. The teachers of the course go through standard examples of the various components of the B-reading system. The course participants then review a series of practice examples with mentors overseeing the practice examples. At the end of the weekend there is an exam. (RX 1, pp. 32-33). The

certifying exam is six hours long with 120 chest x-rays to be categorized. (RX 1, p. 34). Dr. Meyer has recently been asked to have a more active academic role with the B-reader course. (RX 1, p. 32).

Dr. Jeffrey W. Selby examined Petitioner at the request of Respondent's counsel on April 24, 2013. (RX 2, pp. 7-8). Dr. Selby is board certified in internal medicine and pulmonology. He has been a B-reader since 1985. (RX 2, p. 3). Dr. Selby has a general pulmonology practice that entails both inpatient and outpatient. He does all manner of consultation work as far as chest, lungs or breathing disorders. His practice also encompasses occupational lung disease including individuals with coal workers' pneumoconiosis. (RX 2, pp. 4-5). Dr. Selby testified that the board certification of pulmonary disease was first recognized in 1941. (RX 2, p. 26).

Petitioner reported to Dr. Selby 26¾ years of coal mine employment with all of that being underground. He reported to Dr. Selby that he now goes camping and takes care of 17 acres and four horses. (RX 2, p. 9.) Petitioner's chief complaint was shortness of breath. He had noticed his shortness of breath getting worse for the past three to four years. He complained of shortness of breath on exertion. He had a non-productive cough about three to four times per week. He had lost weight which had helped his shortness of breath and snoring. Petitioner reported he could walk one mile on level ground at his own pace. (RX 2, pp. 9-10). Petitioner never smoked. (RX 2, p. 11). On physical examination Petitioner had a BMI of 30 which placed him in the overweight category. Chest exam showed clear breath sounds with good airflow. (RX 2, p. 11).

Dr. Selby caused an EKG to be performed which was abnormal. Dr. Selby also caused a chest x-ray to be performed. He interpreted same as showing no parenchymal or pleural abnormalities consistent with pneumoconiosis. The film was negative for coal workers' pneumoconiosis. (RX 2, p. 12). Pulmonary function testing was also performed. The overall interpretation was normal spirometry without change post bronchodilator. Petitioner had normal lung volumes and normal diffusion capacity. (RX 2, pp. 12-13). Petitioner was placed on a Bruce protocol in exercise testing and completed Stage III or nine minutes of total exercise time. His reason for stopping was left knee pain. (RX 2, p. 13). Dr. Selby testified that petitioner's oxygen saturation on room air was 98% which was normal. Dr. Selby testified that there was not really any significance to the EKG findings for Petitioner. The ST and T-wave abnormality was non-specific, but it could potentially relate to coronary artery disease which would have an effect on his breathing. (RX 2, p. 13).

Dr. Selby testified that a proper reading of a film for pneumoconiosis requires that a B-reader use the standard films and fill out the B-reader form appropriately. Dr. Selby described the standard films as ones that NIOSH supplies each B-reader with for the purposes of reading each x-ray. NIOSH provides standard chest x-rays that reveal a Category 1, Category 2 and

Category 3 pneumoconiosis. The patient's film is put in a view box beside those films when one does a reading of a film. Dr. Selby testified that it is vital to note the opacity type. He testified that there are two different types of shapes of opacities-linear or rounded. He testified that there is not any opacity type known as oblong or square. (RX 2, pp. 16-17). Dr. Selby testified that it is important to note the lung zones involved. (RX 2, p. 17). Dr. Selby also reviewed outside films that were provided to him. Dr. Selby reviewed chest x-rays dated May 8, 2007, February 16, 2012, and March 7, 2012. He also reviewed CT scan of the mid and lower lung zones which did not provide him the opportunity to look at the upper lung zones of the chest. The chest x-rays and CT scans that he reviewed did not reveal the presence of pneumoconiosis. Dr. Selby testified that if dust exposure results in pneumoconiosis or pulmonary fibrosis, that is a permanent condition. He testified that if it leads to restriction, obstruction or both, that condition is also permanent. (RX 2, pp. 18-19).

Dr. Selby testified that when simple coal workers' pneumoconiosis is present and the exposure ceases, it is very unlikely that the disease will progress. Dr. Selby agrees with the position taken by the American Thoracic Society that an older worker with a mild pneumoconiosis may be at low risk for working in currently permissible exposure levels until he reaches retirement age. (RX 2, p. 19).

Dr. Selby testified that pulmonary impairment in a patient is determined by static and dynamic testing such as with pulmonary function testing or exercise testing. Petitioner's spirometry was normal. It revealed no obstruction. His lung volumes were normal and revealed no restriction. Petitioner's diffusion capacity was normal which indicated there was no impairment in gas exchange. (RX 2, p. 20). To have a valid diffusion capacity test, it must be performed properly in a proper facility with proper coaching. Dr. Selby testified this would include proper tracer gas calibration, inhalation smoothly over two seconds, breath hold from nine to eleven seconds, inhalation of at least 85% of the largest vital capacity and a smooth exhalation over approximately six seconds. He testified that one does not know if the diffusion capacity testing is valid unless it follows those guidelines. (RX 2, pp. 20-21).

Dr. Selby testified, based on the objective testing he performed on the Petitioner, he was capable of heavy manual labor. Based on his occupational and medical history, physical examination and laboratory data, Dr. Selby concluded that Petitioner did not suffer from any respiratory or pulmonary abnormality as a result of coal mine dust inhalation or his coal mine employment. He had the respiratory and pulmonary capacity to perform any and all of his previous coal mine duties including his last job working as a shuttle car operator. Dr. Selby noted that Petitioner had obesity which was contributing to his shortness of breath. Petitioner was out of shape or deconditioned which was contributing to his exercise intolerance. Even with his deconditioning, he demonstrated no cardiac or pulmonary limitation in his exercise test

which showed normal results. (RX 2, pp. 21-22). Dr. Selby reviewed treatment records regarding Petitioner covering years April 1977 to August 2012. Those records included cardiopulmonary exercise testing performed on April 29, 2005. That testing revealed a super performance by a normal individual. He was within 10 seconds of completing Stage IV Bruce protocol which is a very vigorous power output requirement. (RX 2, p. 23). Dr. Selby testified that this was the best overall test to look at the function of the heart and lungs. (RX 2, pp. 23-24). Dr. Selby testified that the results of his exercise testing were what he would expect to see of a normal, healthy 66-year-old male. (RX 2, p. 25). Dr. Selby testified that cough is not considered an objective determinant of pulmonary impairment. Dr. Selby testified that from his review of Petitioner's treatment records, he did not have chronic bronchitis. The medical records did not reveal any pathologic evidence of pneumoconiosis. (RX 2, pp. 25-26).

Dr. Selby testified that for a person to have coal workers' pneumoconiosis, in addition to having coal mine dust in the lungs, a tissue reaction is required. This tissue reaction is called scarring or fibrosis. Dr. Selby testified that by definition if a person has pneumoconiosis, he would necessarily have impairment in the function of his lung at the very site of the scarring whether that impairment can be measured by spirometry or not. (RX 2, p. 28). Dr. Selby testified that removal from any further exposure to coal dust is the only treatment for coal workers' pneumoconiosis. He testified that if a person continues his exposure after he has pneumoconiosis, it is a chronic, slowly progressive disease. (RX 2, p. 32). Dr. Selby testified that if a coal miner leaves the coal mine environment with Category 1 pneumoconiosis and does not have any more exposure, in the vast majority of cases, pneumoconiosis does not progress. (RX 2, pp. 33-34). Dr. Selby testified that if an individual had Category 1 radiographic coal workers' pneumoconiosis, he probably would not be having abnormal pulmonary function tests or blood gases or physical examination of the chest or symptoms. (RX 2, p. 35).

Dr. Selby disagreed with the literature cited in the Federal Register of December 2000 considering incidence of obstructive lung disease for coal mine dust inhalation. He testified that the global literature was being applied to a specific region of our country, and it was never intended for that. Dr. Selby testified that his experiences were from the tristate region when he sees nothing near the degree of obstruction purely from coal mine dust exposure as what is purported to occur in the literature from international studies. (RX 2, pp. 37-39). Dr. Selby testified that in the course of treating hundreds or thousands of coal miners over the last 25 years, it is rare that someone has chronic obstructive pulmonary disease purely from coal mining. (RX 2, p. 37).

Medical records form Prairie Cardiovascular Consultants were admitted into evidence. The first report is dated July 30, 1997. At that time, Petitioner underwent a nuclear stress test. Same was interpreted as revealing a normal left ventricular size and function. (RX 4, p. 63). On

April 13, 2005, Petitioner was seen by Dr. Moses at Specialty Physician Center because of a syncopal spell. He gave a history of prior syncopal spells. In the most recent event occurring on April 9, 2005, Petitioner felt dizzy and weak while walking to his barn and then passed out entirely. He was unconscious for 15 to 20 minutes. He was admitted to the hospital where his workup was negative. Review of systems respiratory revealed no problems. Physical examination of the chest revealed the lungs clear to auscultation without rales, wheezes or rhonchi. (RX 4, pp. 56-58). Petitioner was next seen on May 9, 2005. It was noted that Petitioner's echocardiogram showed an ejection fraction of 76% and a slightly elevated right ventricular systolic blood pressure. Review of systems revealed denial of chronic cough by Petitioner. Physical examination of the chest revealed the lungs clear to auscultation without rales, rhonchi or wheeze. The doctor believed Petitioner's syncope was due to neurogenic cardiac syncope. (RX 4, pp. 49-50). Petitioner returned on December 9, 2005. It was noted that Petitioner was very active physically and had no exercise intolerance. Review of systems respiratory revealed no chronic cough. Physical examination of the chest revealed his lungs to be clear to auscultation. (RX 4, pp. 40-43).

Petitioner was seen on July 5, 2007. An EKG was performed and was once again abnormal. The examination was being performed for preoperative clearance. Petitioner underwent a nuclear stress test that revealed a left ventricular ejection fraction of 67%. He had no significant ST-wave changes over baseline. Petitioner denied dyspnea or dyspnea on exertion. Review of systems respiratory revealed no chronic cough. Physical examination of the chest revealed the lungs to be clear to auscultation. (RX 4, pp. 21-25). Petitioner was seen on May 20, 2013, for abnormal EKG. He reported having undergone a treadmill ECG which was positive, therefore he was sent for evaluation. He had a mild to moderate degree of dyspnea on exertion. Petitioner related that overall his physical tolerance was actually getting better since he started intentionally losing weight since January 2013. Review of systems respiratory revealed no chronic cough. Physical examination of the chest revealed the lungs clear to auscultation. It was charted that Petitioner had some dyspnea on exertion which could be an angina equivalent. (RX 4, pp. 5-8). Petitioner underwent a stress test on May 23, 2013. Same revealed a normal exercise cardioperfusion with normal left ventricular systolic function. Treadmill exercise electrocardiogram revealed no myocardial ischemia. Compared to the previous profusion scan of July 2007 there was no significant interval change. (RX 4, p. 3).

Medical records of Litchfield Family Practice were admitted into evidence. The first office note is dated December 14, 1998. On that date, Petitioner's lungs were clear. It was noted that Petitioner had suffered a syncopal episode. Petitioner was seen on January 12, 1999, with complaint of sinus drainage, congestion and a productive cough. His lungs were clear on examination. The assessment was sinusitis. (RX 5, p. 224). Petitioner was next seen on March 11, 1999, with complaint of productive cough, greenish in color, sinus congestion and

drainage. Examination of the chest revealed coarse breath sounds in the upper airways with decreased breath sounds throughout. The assessment was bronchitis. (RX 5, p. 223). Petitioner was seen on May 15, 2000, with complaint of chest congestion and sinus trouble for 10 days to two weeks. He had been coughing up a greenish phlegm. Physical examination of the chest revealed the lungs to have a few faint rales over the middle to lower lobe on the right. No rhonchi were noted. The left lung was clear. The assessment was bronchitis with sinusitis. (RX 5, p. 221). Petitioner was next seen on May 22, 2000, for recheck of his lungs and blood pressure. Physical examination of the chest revealed the lungs clear to auscultation bilaterally. The assessment was bronchitis resolved. (RX 5, p. 220). Petitioner was seen on September 18, 2000, for blood pressure recheck. On that date he related some rhinorrhea and cough for the past two weeks but stated he was about over same. Physical examination of the chest revealed the lungs to be clear. (RX 5, p. 219). Petitioner's lungs were found to be clear when he was seen on April 5, 2001, April 12, 2002, April 30, 2003, November 28, 2003, May 11, 2004, and December 8, 2004. (RX 5, pp. 214-218).

Petitioner was seen on June 22, 2005, at which time he was feeling well. Review of systems respiratory revealed no cough or difficulty breathing. Physical examination of the chest revealed the lungs to be normal. (RX 5, pp. 209-210). Petitioner received correspondence dated November 4, 2005, from NIOSH informing him that the chest x-ray he underwent on September 7, 2005, had been interpreted as revealing no evidence of pneumoconiosis. (RX 5, pp. 357-359). Petitioner returned to the office on December 19, 2005, relating that he had a lung x-ray at work and brought a copy of his last chest x-ray for review. Review of systems respiratory revealed no cough or difficulty breathing. Physical examination of the chest revealed normal breath sounds. (RX 5, pp. 205-207). Petitioner was seen on July 5, 2006, for a six month recheck. Review of systems respiratory revealed no cough or difficulty breathing. Physical examination of the chest revealed no adventitious sounds. (RX 5, pp. 201-203). Petitioner was seen on January 2, 2007, complaining of cough, runny nose and watery eyes. His cough was productive. Examination of the chest revealed normal breath sounds. The doctor's assessment included upper respiratory infection. (RX 5, pp. 193-195). Petitioner underwent a CT of the abdomen at St. Francis Hospital on April 10, 2007, the CT caught the bases of the lungs and revealed calcified granulomas in the right lower lobe and a tiny non-calcified indeterminate pulmonary nodule in the left lower lobe three millimeters in size. (RX 5, pp. 352-353). Review of systems respiratory on April 9, 2007, and May 18, 2007, revealed no cough or difficulty breathing. (RX 5, pp. 187, 190). Petitioner was seen on November 6, 2007, for hypertension management. Review of systems respiratory revealed no cough or difficulty breathing. Physical examination of the chest revealed normal breath sounds. (RX 5, pp. 176-178).

Petitioner underwent CT of the chest on May 12, 2008. The radiologist found evidence of prior granulomatous disease. There was also a non-calcified pulmonary nodule in the left base which was believed to represent the structures seen on the prior study. (RX 5, p. 298). On September 8, 2008, Petitioner was seen complaining of an earache. Review of systems respiratory revealed no cough or difficulty breathing. (RX 5, pp. 165-166). Petitioner underwent a CT of the chest on November 6, 2008. The indication for same was pulmonary nodule of the left lower lung. There was a seven millimeter calcified granuloma noted in the posterior right lung base and a four millimeter non-calcified pulmonary nodule seen in the posterolateral left lower lung which most likely represented a non-calcified granuloma. No additional or new pulmonary nodules were seen at either lung base. (RX 5, p. 294).

Petitioner's review of systems respiratory revealed no shortness of breath on June 17, 2009, December 21, 2009, or July 19, 2010. (RX 5, p. 149, 156, 160). Review of systems respiratory on October 29, 2010, revealed no persistent cough but cough that comes and goes and no difficulty breathing. Physical examination of the chest revealed no adventitious sounds. (RX 5, pp. 145-146). Petitioner was seen on March 25, 2011, for blood pressure check. On that date his review of systems respiratory was negative for cough and difficulty breathing. (RX 5, pp. 141-142). He likewise had no cough or difficulty breathing on October 6, 2011. (RX 5, pp. 137-138). Petitioner was seen at St. Francis Hospital Emergency Room on February 16, 2012, after a syncopal episode. He denied shortness of breath. On examination his lungs were clear to auscultation. (RX 5, pp. 259-263). Petitioner's review of systems respiratory revealed no cough or difficulty breathing on March 2, 2012, March 26, 2012, and August 13, 2012. (RX 5, pp. 119, 124, 127-128). Petitioner was seen on February 19, 2013, for hypertension management. Review of systems respiratory revealed no cough or difficulty breathing. Review of systems cardiovascular revealed no shortness of breath. Physical examination of the chest revealed normal breath sounds. (RX 5, pp. 93-94). Petitioner was seen on May 8, 2013, with complaint regarding abnormal EKG. It was charted that he had an abnormal EKG when examined in Kentucky and was advised to see his primary care physician in follow up. An EKG was repeated and noted to be the same as that performed in February 2012. Petitioner was complaining of sinus pain as well as conjunctivitis, cough, headache, nasal stuffiness and runny nose. Review of systems respiratory revealed cough but no difficulty breathing. He had no shortness of breath. Physical examination of the chest revealed normal breath sounds. The assessment included sinusitis. (RX 5, pp. 88-89). Review of systems respiratory revealed no cough or difficulty breathing on September 26, 2013, October 14, 2013, and November 4, 2013. (RX 5, pp. 81, 84-85).

Petitioner was seen on April 8, 2014. He reported that he was feeling well and life was good. Review of systems was negative aside from hypertension. Physical examination of the chest revealed normal breath sounds and no adventitious sounds. (RX 5, pp. 71-73). On April

29, 2015, Petitioner was walking a mile three times a week. Physical examination of the chest showed normal breath sounds and no adventitious sounds. (RX 5, pp. 47-49). Petitioner was seen on June 17, 2015, for transitioning to the care of Litchfield Family Practice Center from the emergency room in Minnesota following the "seizure" incident in Minnesota. Review of systems respiratory was completely negative. Physical examination of the chest and lung showed normal breath sounds. (RX 5, pp. 32-34). Petitioner was seen on November 4, 2015, for recheck of knee pain and hypertension. Review of systems respiratory was negative for cough and difficulty breathing. Breath sounds were normal on examination. (RX 6, pp. 3-4).

CONCLUSIONS OF LAW

The Arbitrator adopts the above Findings of Fact in support of the Conclusions of Law set forth below.

1. Petitioner was last exposed to the hazards of an occupational disease in the course of his employment on April 3, 2009. Petitioner's Application for Adjustment of Claim was filed on August 21, 2012. Section 6(c) of the Occupational Diseases Act contains no specific reference to COPD and does not define coal workers' pneumoconiosis so as to include COPD or other respiratory conditions related to coal dust exposure. The five-year limitations period prescribed by Section 6(c) applies only to claims for disability caused by coal miner's pneumoconiosis. Carter v. Illinois Workers' Compensation Comm'n, 2014 IL App. (5th) 130151 WC ¶20. Petitioner's claim for benefits related to any occupational disease other than coal workers' pneumoconiosis is barred by the three year statute of limitations in Section 6(c) of the Occupational Diseases Act.

2. Petitioner has failed to prove by a preponderance of the evidence that he sustained an occupational disease arising out of and in the course of his employment. The Arbitrator finds the B-readings of Drs. Meyer and Selby as well as the independent NIOSH B-readers to be more persuasive. In particular the Arbitrator finds the testimony of Dr. Meyer insightful, informative and persuasive. His background and experience in radiology, B-reading and coal workers' pneumoconiosis were impressive and beyond that of Petitioner's physician, Dr. Paul, who is not a B-reader.

3. Petitioner has failed to prove by a preponderance of the evidence that his current condition of ill-being is causally connected to his employment.

4. Petitioner has failed to prove by a preponderance of the evidence that he suffered a timely disablement under Section 1(f) of the Occupational Diseases Act.

5. Petitioner's claim for benefits is denied.

Signature of Arbitrator

February 10, 2016
Date

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Leonard Cerniglia,
Petitioner,
vs.

City of Chicago,
Respondent.

17IWCC0009
NO: 03 WC 1572

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 disabilityand 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 15, 2016 is hereby affirmed and adopted.

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

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

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

DATED: JAN 17 2017
KWL/vf
O-1/10/17
42

Kevin W. Lamborn

Michael J. Brennan

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

17IWCC0009

CERNIGLIA, LEONARD
Employee/Petitioner

Case# **03WC001572**

CITY OF CHICAGO
Employer/Respondent

On 3/15/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.51% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0207 STUART H GALESBURG
221 N LASALLE ST
SUITE 2017
CHICAGO, IL 60601

0010 CITY OF CHICAGO
STEPHANIE LIPMAN
30 N LASALLE ST SUITE 800
CHICAGO, IL 60602

L. Cerniglia v. City of CHGO , 03 WC 01572

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

CORRECTED

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

17IWCC0009

Leonard Cerniglia
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # 03 WC 01572

An *Application for Adjustment 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 **12/1/15 & 12/8/15**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

L. Cerniglia v. City of CHGO , 03 WC 01572

FINDINGS

On **11/18/02**, 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 **$53,872.00**; the average weekly wage was **$1,036.00**.

On the date of accident, Petitioner was **54** years of age, *married* with **0** dependent children.

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

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

Respondent shall be given a credit of **$146,487.80** for TTD, **$0** for TPD, **$187,672.86** for maintenance, and **$0** for other benefits, for a total credit of **$334,160.66**.

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

ORDER

Respondent shall pay Petitioner TTD and Maintenance benefits of $690.67/week for 483-6/7 weeks, pursuant to §8(b) and 8(a), as is set forth below.

Respondent shall pay Petitioner permanent total disability benefits of $690.67/week for life, commencing December 1, 2015, as provided in §8(f) of the Act.

Commencing 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 §8(g) of the Act.

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

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

Signature of Arbitrator

March 2, 2016
Date

ICArbDec p. 2

MAR 15 2016

FINDINGS OF FACT

Petitioner was employed by Respondent as a Motor Truck Driver in the Department of Streets and Sanitation. In this position, Petitioner drove a truck. This was not a physical job. He began employment with Respondent in 1995.

The Parties stipulated that Petitioner sustained accidental injuries which arose out of and in the course of his employment by Respondent on November 18, 2002. He slipped while climbing into a truck and he twisted his back.

Petitioner previously underwent a lumbar laminectomy in 1978. He had a right foot drop at that time, which at trial he described as similar to that which he experienced in 2002 and subsequently. He admitted that the foot drop resolved "pretty much" after the 1978 surgery, but was still there "slightly". This condition did not prevent Petitioner from working full time as a truck driver in Chicago. This prior incident was a result of a work injury, which Petitioner settled. He does not recall if it was explained to him that he closed out his medical rights on that injury when he settled the claim.

Petitioner reported his injury and was instructed to go to Respondent's Occ. Med. facility at MercyWorks for treatment. Petitioner was referred to Dr. Frank Phillips, an orthopedic surgeon, by MercyWorks for treatment. Dr. Phillips noted lower extremity claudication symptoms, with a frank right foot drop. Petitioner noticed lots of pain in his low back on the right side, radiating down the buttocks and down his leg. He had a right foot drop. Conservative measures failed, so surgery was offered by Dr. Phillips.

Petitioner underwent surgery on 2/11/03 at Mercy Hospital. Dr. Phillips performed a L2-L5 laminectomy with medial facetectomy and foraminotomy; L2-L5 posterolateral intertransverse fusion; L2-5 pedicle screws rod fixation using ZS system; and Autogenous iliac crest bone graft harvest. (PX#2)

Petitioner testified that his back and leg pain decreased after this surgery. Petitioner felt pretty good after surgery. The foot drop also improved, but it never went away.

A Work Capacity Evaluation, dated 10/7/03, indicated that Petitioner was functioning at a light/medium to medium duty work level. It further noted that it was uncertain if he would be able to return to work as a truck driver and noted that he was able to lift 35#s from floor to overhead and 47# from floor to knuckle. He needed light/medium clearance to return to work. The test was reported as valid. (PX#3)

Petitioner was discharged from treatment with restrictions and subsequently returned to work for Respondent within said restrictions. He testified that he was brought in for an interview and then hired as an Equipment Dispatcher in Traffic Services. He began working in this position on 5/1/04. He testified that he worked "at least" 40 hours a week in this position.

Petitioner was examined at Respondent's request on 7/26/06 by Dr. Julie Wehner, who reviewed his medical records, MRI film and performed a clinical examination. On exam, it was noted that his gait was normal and he was able to heel walk on right but that his right foot comes up less than on the left. He was able to toe walk normally and the SLR was negative. Her diagnosis was spinal stenosis with foot drop. Dr. Wehner opined that Petitioner suffered an aggravation of a pre-existing stenosis condition and further opined that he should not

return to work as a truck driver, agreeing with his permanent restrictions. She also placed him at maximum medical improvement. (RX#1)

Petitioner was paid TTD by Respondent from November 19, 2002 through April 30, 2004.

Petitioner testified that he later began to feel numbness in his legs. He could only walk a few blocks. He saw Dr. Phillips on 11/1/07. Petitioner reported that for the past few months there was heaviness and a weakness in his legs when he ambulated more than 20 feet. On exam he had trace ankle dorsiflexion weakness on the right, but strength was still 5/5. Dr. Phillips thought that Petitioner's complaints were due to adjacent level stenosis at L1-L2. Epidural injections were recommended. (PX#3 A)

Petitioner returned to Dr. Phillips on 1/10/08. He had last worked on 1/6/08. The doctor noted that Petitioner had developed L1-2 severe stenosis adjacent to his prior fusion. Petitioner was unable to walk at all without a feeling of heaviness and weakness in his legs and was using a walker to ambulate. Dr. Phillips recommended decompression and extension of the fusion up to L1-2. The procedure is related to the first surgery that Dr. Phillips performed. Petitioner was experiencing a disabling claudication syndrome. Dr. Phillips did not restrict Petitioner from work on that date. Petitioner testified that he stopped working before he saw Dr. Phillips. (PX#3 B)

On 1/30/08, Dr. Phillips provided Petitioner with a back dated off work slip. It removed Petitioner from work as of 1/10/08 to "adequate surgical healing as occurred". (PX#3 C) Petitioner was not paid TTD for the time period of 1/7/2008 through 1/30/2008.

On 2/4/08, Dr. Phillips performed a second surgery. He removed hardware at L2-L5, screws, rods, crosslink, explored the fusion, performed a L1-2 laminectomy, decompression of bilateral L1, 2 nerve roots and a revision L1-L3 posterior spinal fusion with a Xia Striker titanium system. (PX#4)

Petitioner testified that, after the second surgery, he had numbness in both legs which radiated to his feet. He had weakness. He had to use a walker. After this procedure, Petitioner has not returned to work anywhere.

Petitioner testified that as of the summer of 2008, he was feeling more stable and taking less pain pills. His strength had improved since he began physical therapy.

Petitioner returned to MercyWorks on 11/18/08. It was noted that he had been recently revaluated by Dr. Phillips. Note was made of his ongoing right foot drop and complaints of bladder dysfunction; bracing was advised. (PX#3 D)

Petitioner underwent a third surgery by Dr. Phillips on 1/26/09. The procedure was an exploration of fusion; removal of loose implants; posterior spinal instrumentation from T9-L3; posterior spinal fusion from T9-L3; posterior spinal decompression of T9-10, T10-11, and T12. (PX#5) So, after this procedure, Petitioner's spine had been fused by Respondent's choice of orthopedic surgeon from T9 to L5.

Petitioner testified that after this surgery he noticed improved strength in his right leg. As of May of 2009, he was only using Tylenol for pain.

On 5/13/10, Dr. Phillips wrote a letter addressing Petitioner's condition. Petitioner has a multilevel thoracolumbar fusion. Petitioner has significant lower extremity weakness and cannot ambulate without the assistance of a cane. Dr. Phillips opined: "I do not believe that Mr. Cerniglia is capable of working any longer

for the City of Chicago." "I do not believe that (he) is capable of doing anything other than sedentary work", with limited hours and he would require frequent breaks. (PX#5 A)

Petitioner identified a Willingness and Ability Questionnaire for a Watchman position which he completed on 8/12/10. He answered all 9 questions on the document yes, indicating that he was physically able to perform the position. There was no evidence that Petitioner was offered this position, or any similar position by Respondent. (RX#3)

Respondent has not offered Petitioner any job after the second surgery.

Petitioner retained Jeff W. Lucas, PhD, MSW, CRC, etc., to prepare a Vocational Analysis on 7/28/11. Dr. Lucas reported incorrectly that, after the 2003 surgery, Petitioner returned to work as truck driver until September of 2007. He made note of the restrictions placed on Petitioner by Dr. Phillips. It was Lucas' opinion that a stable labor market does not exist for Petitioner, based upon his age, past work experience, education and physical limitations. (PX#6)

There was no evidence that Respondent initiated a Vocational Rehabilitation Program and no evidence that a Vocational Rehabilitation Plan was filed, as required by Rule 7110.10. Respondent did not offer Petitioner retraining or job search assistance.

Respondent retained MedVoc, Natalie M. Martin, MA, CRC, to provide an initial vocational evaluation regarding Petitioner. Ms. Martin's report of April 26, 2013 does not set forth a formal plan because Petitioner had not been released to work by any physician. She needed a work release or an FCE. If Petitioner was released to sedentary work, then a focus on dispatcher positions was appropriate. (PX#7)

On 2/5/13, Dr. Phillips noted that Petitioner still had a persistent right foot drop and significant lower extremity weakness which was related to his underlying congenital stenosis. Petitioner reported taking Tylenol, as needed. Dr. Phillips believed that Petitioner is unable to do any type of physical labor and stated that he supports Petitioner's ongoing disability claim. (PX#8)

On 6/18/13, Petitioner was examined by Dr. Daniel Troy at Respondent's request. Dr. Troy was unable to say whether Petitioner's current condition was related to the initial injury. He noted that there was a right foot drop that led to an antalgic gait and intermittent use of a cane for ambulation. He further opined that Petitioner required no further treatment for his thoracic or lumbar spine and could have returned to work as of July, 2009 working at a sedentary level. He noted that Petitioner could return to work as a dispatcher, the position that he had in 2008, but that he was unable to return to his original job duties of a MTD. (RX#2)

On 6/4/15, Petitioner reported to Dr. Phillips for his annual follow up exam. The doctor noted that "He is about the same". Petitioner continues to have some back pain and a right foot drop. The doctor commented that Petitioner was unable to do any type of physical labor. Dr. Phillips supported Petitioner's ongoing disability claim. (PX#8)

Respondent paid Petitioner additional lost time benefits from January 31, 2008 through November 27, 2015. The total amount of compensation paid is $334,160.66. Respondent claims Petitioner is entitled to TTD from 11/19/02 - 4/30/04 and 1/31/08 - 9/12/2010. Respondent disputes liability for lost time benefits after 9/12/2010. Petitioner claims benefits from 1/10/2008 through the time of trial. (ArbX#1)

Respondent required Petitioner to perform job search activities in order to receive lost time benefits. Petitioner would prepare job search logs and submit them to a contact at Respondent. He turned in these documents from March of 2010 through November 30, 2015. Petitioner submitted a stack of job search logs into evidence. (PX#11) He was questioned about his job search. He admitted to submitting no more than 10 job searches per week. He was advised to do at least 10 searches per week by an agent of Respondent. Petitioner admitted that the majority (approximately 95%) of the jobs for which he applied were for dispatcher positions. The job logs do not provide a contact person at the prospective employers. Petitioner agreed that this prevented Respondent from following up with the prospective employer and verifying his job search. All of his job searches were on line. He also admitted that he failed to submit confirmation sheets with his job logs. Therefore, there was no way for Respondent to verify that he actually applied for the positions on line that he claimed that he did. He never looked for work in person. He did follow up on contacts that he made, albeit, not in person.

Petitioner also admitted that he did not look on websites belonging to the City of Chicago, the County, the State or any other municipality for employment. Petitioner took a test at Respondent for a Supervising Traffic Enforcement Technician at Respondent in July of 2013, but he failed. (RX#4)

Petitioner agreed that it was his burden to establish that his job search was conducted to the best of his ability. There was no evidence that Respondent advised Petitioner that his job search efforts were defective or unacceptable.

Petitioner is to follow up with Dr. Phillips every two years. Petitioner testified to the pain that he now experiences. He has numbness in the right leg, both feet and groin. He has pain in the right buttock. He has a drop foot. Driving is difficult, but he does it. He has difficulty with activities of daily living. He also testified that he avoids painkillers. His current pain medication (Norco) is from his primary care physician. He also takes Tylenol. He gets off his feet to relieve pain.

Petitioner still has a right foot drop and uses a cane. He has a foot brace but does not always wear it. He does not wear it when he drives. He was not wearing it the day of his workers' compensation hearing. He did not drive to the Commission on the date of his hearing. He drove his car to the Blue Line at Harlem and Washington and took the CTA to the City.

Petitioner drives every day. He drives approximately every two weeks to Crystal Lake to visit his mother. He has a recumbent bike which he uses frequently. It provides cardiovascular exercise. He does not use his cane in his house, only outside.

Petitioner was 67 years old at the time of trial. He is a Medicare recipient. He had a high school degree from Lane Tech. He was in the National Guard for a couple of years in the 1960's. He has been a truck driver for most of his life. Petitioner's medical condition is complicated by several co-morbids, to wit: Type II DM; CAD with heart attack in 1996; hypertension; high cholesterol; leukemia. He was able to perform his job duties as a MTD for Respondent at the time of the accident.

CONCLUSIONS OF LAW

The Arbitrator adopts the above Findings of Fact in support of the Conclusions of Law set forth below. The Arbitrator finds Petitioner's testimony to be credible.

F.) Causal Connection

The Arbitrator finds that Petitioner's current condition of ill-being regarding his low back (spinal stenosis with foot drop, aggravated by work accident of November 18, 2002 leading to 3 subsequent back surgeries with the eventual fusion of the spine from T-9 – L5, with residual disability and complaints as set forth above) to be causally related to the accidental injuries of November 18, 2002, based upon the unrebutted testimony of Petitioner and the medical records.

Petitioner had a prior operated back with a residual foot drop, but this condition did not prevent him from working as a MTD for Respondent. After the accident, Petitioner never returned to work. The submitted documents from Dr. Phillips (orthopedic surgeon that Petitioner was referred to by Respondent's clinic) document a causal connection between the injury and the 3 subsequent surgeries.

K.) TTD and Maintenance

Petitioner is entitled to TTD benefits from November 19, 2002 through April 30, 2004 (75-6/7 weeks) and January 31, 2008 through September 12, 2010 (136-4/7 weeks). Petitioner took himself off work effective January 7, 2008 and Dr. Phillips' ex post facto off work slip of January 30, 2008 is not persuasive in awarding TTD prior to January 31, 2008.

Additionally, Petitioner is entitled to Maintenance benefits from September 13, 2010 through the date of hearing, December 1, 2015 (271-3/7 weeks). Petitioner performed a good faith job search via Respondent's approved methods. Respondent continued paying benefits to Petitioner and never advised him that his job search was defective or unreasonable. Respondent did not file a Voc Plan and did not provide Petitioner with vocational rehab services and job search assistance, although Petitioner could obviously not return to work as a MTD and would need such help to find gainful employment, given the limitations post the 3 surgeries (with resultant T9-L5 fusion) provided by Respondent's orthopedic surgeon.

Thus, Petitioner is entitled to 483-6/7 weeks of lost time benefits. Respondent is entitled to a credit for the $334,160.66 that it has paid.

L.) Nature and Extent

Based upon the evidence adduced, Petitioner has proven that the injuries sustained caused his permanent and total disability, in accordance with §8(f) of the Act.

In finding that Petitioner is permanently and totally disabled, the Arbitrator relies upon the credible testimony of Petitioner, the medical records and the opinion of Jeff Lucas, PhD. Petitioner had significant restrictions and limitations after undergoing the 3 back surgeries after his accident. Petitioner was 67 years old at the time of

trial. His work experience was limited to being a truck driver. He had a high school education and was provided with no vocational assistance by Respondent. Given the proofs in this case, Petitioner's job search efforts (de facto endorsed by Respondent) were adequate and in good faith. Dr. Phillips endorses Petitioner's ongoing disability claims and the Arbitrator concurs and finds Dr. Phillips' opinion to be credible and persuasive.

N.) Is Respondent due any credit?

Respondent is entitled to a credit against this award for the $334,160.66 in lost time benefits that it paid Petitioner.

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

Marshall Price,
Petitioner,
vs.

17IWCC0010
NO: 15 WC 22665

Elgin Sweeper Company,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, temporary total disability, 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 April 7, 2016 is hereby affirmed and adopted.

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

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

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

DATED: JAN 17 2017
KWL/vf
O-1/10/17
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

17IWCC0010

PRICE, MARSHALL
Employee/Petitioner

Case# **15WC022665**

ELGIN SWEEPER COMPANY
Employer/Respondent

On 4/7/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

2512 THE ROMAKER LAW FIRM
TOD ALLSWANG
211 W WACKER DR SUITE 1450
CHICAGO, IL 60606

1120 BRADY CONNOLLY & MASUDA PC
MARK VIZZA
10 S LASALLE ST SUITE 900
CHICAGO, IL 60603

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

17IWCC0010

MARSHALL PRICE
Employee/Petitioner

v.

ELGIN SWEEPER COMPANY
Employer/Respondent

Case # 15 WC 22665

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 **Gerald Granada**, Arbitrator of the Commission, in the city of **Chicago**, on **March 16, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On 5/19/2015, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $31,474.04; the average weekly wage was $605.27.

On the date of accident, Petitioner was 43 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 $0.00 for TTD, $0.00 for TPD, $0.00 for maintenance, and $2,587.04 for other benefits, for a total credit of $2,587.04.

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

ORDER

Petitioner failed to meet his burden of proof regarding the issues of accident and causation. Accordingly, the Petitioner's claim for 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

4/6/16

Date

APR 7 - 2016

17IWCC0010

FINDINGS OF FACT

In this matter, Petitioner is alleging he sustained an injury to his right foot while working for the Respondent on May 19, 2015. Respondent is disputing Petitioner's claim and the issues in dispute are: 1) accident, 2) notice, 3) causation, 4) medical expenses, 5) TTD, 6) penalties/fees, and 7) nature and extent. This matter was originally venued in Elgin, but the hearing was held in Chicago.

Petitioner testified that he has worked for the Respondent for three years prior to his alleged accident date. He is currently working as a Master Shipper-Receiver. At the time of his alleged accident, he was working as a forklift driver. As a forklift driver, he made sure each line had the material they needed or parts to build a truck. He would have to deliver parts throughout the entire facility. When he first started working as a forklift driver, he delivered parts by forklift. In February 2015, his job duties changed, as the job positions are changed every six months. His job duties were different and his new position required the Petitioner do more walking. Petitioner was also required to wear steel-toed shoes, which he ordered through the Respondent's company website. The shoes he ordered had a thick rubber sole. He testified the shoes were not comfortable. When he switched jobs, he began to notice he was getting pain in his right foot. From February 2015 through May 19, 2015, he was having right heel pain. On May 14, 2015, his foot was hurting really bad. He worked through May 19, 20115.

The Petitioner testified he spoke with his supervisor, Eduardo Delatorre. He told Delatorre that he was having a problem with his heel. He testified Mr. Delatorre told him he had the same problem that would go away. He testified that he later told Mr. Delatorre he needed a forklift because it was very hard to be doing all the walking. Petitioner told Mr. Delatorre that he would miss work and that he was going to go to the emergency room.

Petitioner went to the emergency room of St. Joseph Hospital on May 20, 2015, where he told the emergency room staff that he had pain in his right heel. He was referred to Greater Elgin Family Healthcare the next day, where he gave them a history of having pain in his right foot for three months. Petitioner told them the pain in his heel was aggravated by walking and standing. On May 21, 2015, Greater Elgin Family Healthcare gave him a letter stating that he was not to return to work until he saw a specialist. On June 4, 2015, Greater Elgin Family Healthcare gave him a letter stating he was able to return to work without restriction on June 4, 2015.

The Petitioner did not return to work on June 4, 2015 with his full duty release, because he was involved in a motor vehicle accident. Following this motor vehicle accident, Petitioner began treating with Dr. Fink of Gold Coast Orthopedic and Hand Surgery on June 24, 2015. The doctor there took him off work on June 24, 2015. He had physical therapy from July 13, 2015, to August 13, 2015. Dr. Fink performed surgery on Petitioner's right foot on October 15, 2015. Dr. Fink diagnosed Petitioner with right plantar fasciitis and calcaneal spur on the right foot. Dr. Fink performed a partial plantar fasciotomy and an excision of the calcaneal spur. Petitioner developed an infection in his right foot after the surgery for which he underwent a second procedure on his foot on November 5, 2015. The Petitioner was returned to work restricted duty on January 18, 2016. He still has pain with walking.

Eduardo Delatorre was called by Respondent to testify. He testified that he works for Respondent as a Warehouse Supervisor. He oversees a team of about 20 or 21 people whose daily activities are picking, transporting, and sorting material. He was in this position in 2015. Petitioner was one of the employees on his team in 2015. In 2015, Petitioner was a Material Handler, whose responsibilities involve moving material around the plant floor. Moving the materials could be done in a variety of different ways, including manually

picking parts, moving them on carts, or using a forklift for higher stacked materials. The Petitioner had a job change in 2015. There was a group rotation, which is when they move people around within the department to take on different skills, which helps the employees move up within the ranks to gain more skills. They become a more valuable employee based upon the skill set and they can also increase their income by graduating to the different levels. The job change would probably have been effective February 16, 2015. Before February 16, Petitioner's job was delivering and picking materials for a three-wheel assembly line. After February 16, he was picking internal transfer orders. The difference between these two positions is that Petitioner was not dealing with an assembly line, and was instead getting parts for work orders for assembly. Sometimes the requirements could be the same; when the parts are big and bulky, you use a forklift, and when they are small, you just pick them off the shelf. Mr. Delatorre did remember the Petitioner stating he was having some shoe discomfort from the new safety shoes. Mr. Delatorre believed that there is a level of break-in with the shoes at all times, and that he may have told the Petitioner that he was having the same problem.

Mr. Delatorre denied that the Petitioner reported to him he that he was having problems from a work injury for which he needed medical treatment. He did receive a message in June, 2015 that the Petitioner was in a car accident on June 14, 2015. Mr. Delatorre did not recall ever being presented with light duty restrictions for the Petitioner. Mr. Delatorre denied that the Petitioner ever approached him about returning to work for Respondent. Mr. Delatorre testified that Respondent has a procedure for reporting work injuries, and that all employees are informed of these procedures. Mr. Delatorre further testified that the Petitioner never followed these procedures. He confirmed that the Petitioner may have filed an HR grievance against him two years before the Petitioner's alleged date of accident.

Dave Strebel also testified on behalf of the Respondent. He is employed by Respondent as a Senior Environmental Health and Safety Manager. He takes care of environmental issues and safety issues, and handles all issues with safety involving accidents or injuries, including workers' compensation claims. Mr. Strebel confirmed that Respondent has a policy and procedure in place for reporting workers' compensation claims, and that he is involved in this procedure. In his position of handling the Respondent's workers' compensation claims, Mr. Strebel has never had a claim forwarded to him for Petitioner. As part of the safety program, all employees are to required to wear certain footwear, including steel-toed shoes. Employees can either be reimbursed for buying his own shoes, or order them from the company website. There are probably six or seven different brands available, and each brand contains several different types of shoe. Employees could choose boots, regular shoes, or even athletic-wear styles of work shoes. The only requirement is that they wear steel-toed shoes. Respondent's policy is if you try on the shoes and they are not comfortable, or they don't feel right, the Respondent will return them through the HR Department. The HR Department will return them to the company they were ordered from and the employee could request a different pair with no problem. In the past, when an employee has been wearing the shoes for several months, but they are having a problem, the Respondent would authorize a new pair of shoes.

CONCLUSIONS OF LAW

1. Regarding the issue of accident, the Arbitrator finds that the Petitioner has failed to meet his burden of proof. In support of this finding, the Arbitrator relies on both the testimony and the medical evidence presented at trial. Essentially, the Petitioner is claiming an injury to his foot from walking with steel toed boots on May 19, 2015. However, the evidence does not support Petitioner's claim. It is not clear if Petitioner is alleging a repetitive walking injury, or injuries due to his particular footwear or a combination of both claims. The medical evidence shows that the Petitioner was complaining of problems with his foot as early as February, 2015 due to walking

17IWCC0010

and standing. Three months later, in May, 2015, Petitioner was taken off work for his alleged foot condition. He was subsequently given a release to return to work full duty in June, 2015. However, before Petitioner could return to work with no restrictions, he was in a non-work-related motor vehicle accident. Following that non-work-related accident, he continued to receive medical treatment for his foot and was ultimately diagnosed with plantar fasciitis and a right calcaneal spur, for which he underwent surgery. These series of events lead the Arbitrator to believe that the motor vehicle accident may have been ultimately responsible for Petitioner's right foot condition and his need for surgery. But putting the causality questions aside, Petitioner's credibility is also called into question, as the Arbitrator notes that Respondent's witnesses directly rebutted Petitioner's testimony that he reported he had a work accident. Moreover, the evidence show that if the Petitioner was having a problem with his steel toed boots, he could easily have exchanged them for another boot or shoe style, or more comfortable work-appropriate footwear at the expense of the Respondent. In reviewing the totality of the evidence, the Arbitrator concludes that the Petitioner's claim of injury due to walking with steel toed boots does not rise to the level of an accident under the Act, and that Petitioner failed to show that he had an accident while working for the Respondent on May 19, 2015.

2. With regard to the issue of causation, the Arbitrator finds that the Petitioner has failed to meet his burden of proof. In support of this finding, the Arbitrator relies on the testimony and medical evidence introduced at trial. Specifically, the Arbitrator relies on the medical evidence indicating Petitioner had been complaining of foot problems as early as February, 2015 due to standing and walking. Furthermore, it appears that Petitioner's foot conditioned worsened after he was given a full duty release to return to work in June, 2015 and then experienced a non-work related motor vehicle accident. After this non-work related accident, Petitioner was kept off work completely and subsequently underwent surgery for his right foot. These facts lead the Arbitrator to conclude that the Petitioner's motor vehicle accident in June, 2015 served as an intervening event that ultimately broke any possible chain of causation between Petitioner's employment and his right foot condition, and ultimately lead to his need for right foot surgery. Accordingly, the Arbitrator finds that the Petitioner failed to prove that his current condition of ill-being is causally related to his employment.

3. Based on the Arbitrator's findings with respect to the issues of accident and causation, all other issues are rendered moot.

STATE OF ILLINOIS)
) SS.
COUNTY OF WILLIAMSON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Minh Scott,

Petitioner,

vs. No. 15 WC 12972

State of Illinois/Menard Correctional Center,

17IWCC0011

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Petitioner herein and notice given to all parties, the Commission, after considering the issue of the nature and extent of Petitioner's 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 determination of permanent partial disability is governed by section 8.1b(b) of the Workers' Compensation Act, which provides:

> "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." 820 ILCS 305/8.1b(b).

The Commission agrees with the Arbitrator's finding that factors (ii) and (v) merit significant weight, while factor (iii) merits greater weight, factor (iv) merits some weight and factor (i) merits no weight. The Commission also agrees with the Arbitrator's analysis of factors (i) through (iv). However, the Commission finds a greater degree of disability (factor (v)) than the Arbitrator found.

The Commission notes the MRI performed less than two weeks after the accident showed a full-thickness tear of the rectus femoris insertion onto the anteroinferior iliac spine, with a 3 cm retraction. On March 31, 2015, Dr. Mall performed a left rectus femoris repair. Intraoperatively, Dr. Mall noted: "There was extreme tension and fluid underneath [the rectus muscle sheath]. We opened this and a large gush of injury fluid was obtained. *** I then dissected the scar tissue from the rectus. It had already scarred substantially. We were able to free this up and get some mobility of the muscle. There was somewhat poor tissue quality at the proximal aspect of the tendon. This was debrided. Again, the tendon was not of great quality. ¶ I then was able to clearly identify the point of which was avulsed from the bone. There was a bare spot on the anteroinferior iliac spine." Dr. Mall reattached the tendon using sutures and anchors.

Petitioner's postoperative recovery was uncomplicated, and he progressively improved with physical therapy. Petitioner completed physical therapy on August 21, 2015. At the time of discharge, he complained of somewhat limited range of motion in the left hip. On August 25, 2015, Dr. Mall released Petitioner to return to work full duty. Petitioner last saw Dr. Mall on October 13, 2015, reporting doing very well and being able to work full duty and exercise. Petitioner did mention some mild stiffness when putting on his shoes.

During the arbitration hearing, Petitioner credibly testified to his residual symptoms and limitations. Petitioner stated he used to run three miles a day before the accident. Now he can only run about half a mile because "the injury starts hurting, and it gets inflamed." Petitioner went from being able to "squat" between 225 and 400 pounds of weights to squatting 145 pounds of weights. The range of motion in the left leg is now more limited than in the right leg. Petitioner resigned from the tactical unit after 20 years of participation because his left hip "couldn't take the strain." Petitioner now limits his activities in an attempt to spare the hip. The medical records in evidence, particularly the operative report and physical therapy records, corroborate Petitioner's testimony.

The Commission finds the proper measure of disability is 25 percent loss of use of the left leg.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 21, 2016, is hereby modified as stated herein and otherwise affirmed and adopted.

17IWCC0011

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $735.37 per week for a period of 53.75 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the 25 percent loss of use of the left leg.

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

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

Pursuant to §19(f)(1) of the Act, there shall be no right of appeal as the State of Illinois is Respondent in this matter.

DATED: JAN 18 2017
d-12/15/2016
SM/sk
44

Stephen Mathis

Mario Basurto

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SCOTT, MINH
Employee/Petitioner

Case# **15WC012972**

17IWCC0011

SOI/MENARD CORRECTIONAL CENTER
Employer/Respondent

On 7/21/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.43% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

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

0558 ASSISTANT ATTORNEY GENERAL
AARON L WRIGHT
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CARBONDALE, IL 62901

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

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

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

JUL 21 2016

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

17IWCC0011

STATE OF ILLINOIS)
)SS.
COUNTY OF WILLIAMSON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

MINH SCOTT
Employee/Petitioner

v.

STATE OF ILLINOIS/MENARD CORRECTIONAL CENTER
Employer/Respondent

Case # **15** WC **12972**

Consolidated cases: _____

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Christina Hemenway**, Arbitrator of the Commission, in the city of **Herrin**, on **April 14, 2016**. By stipulation, the parties agree:

On the date of accident, **March 13, 2015**, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $**95,328.52**, and the average weekly wage was $**1,833.24**.

At the time of injury, Petitioner was **46** years of age, ***married*** with **0** dependent children.

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

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

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

ORDER

Respondent shall pay Petitioner the sum of **$735.37**/week for a further period of **43** weeks, as provided in Section **8(e)** of the Act, because the injuries sustained caused **20% loss of use of the left leg**.

Respondent shall pay Petitioner compensation that has accrued from **October 13, 2015** through **April 14, 2016**, 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

July 17, 2016
Date

JUL 21 2016

STATE OF ILLINOIS)
) SS
COUNTY OF WILLIAMSON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

MINH SCOTT
Employee/Petitioner

v.

Case #: **15 WC 12972**

STATE OF ILLINOIS/MENARD CORRECTIONAL CENTER
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

The parties stipulated that the only issue in dispute is the nature and extent of Petitioner's permanent partial disability. The parties stipulated that Respondent has paid, or will pay, all related medical bills pursuant to the medical fee schedule as provided in Sections 8(a) and 8.2 of the Act. The parties further stipulated that Respondent will receive credit for all medical bills paid, including those paid under its group plan, for which they will receive a credit pursuant to Section 8(j) of the Act.

On his date of accident, Petitioner was 47 years old, married, with no dependents. He was employed by Menard Correctional Center as a Correctional Lieutenant and had been so employed for approximately twenty years. The parties stipulated that on March 13, 2015, Petitioner sustained an accident which arose out of and in the course of his employment. At that time he was injured in an inmate altercation when the restrained inmate became combative, slipped his cuffs, and began to fight with Petitioner. He sustained injury to his left hip and groin. Petitioner completed an Employee's Notice of Injury following the accident, and indicated injury to his left hip with "serious pain", medium hematoma on the left side of his head, and bruising on the right side of his head. An Employer's First Report of Injury was completed the same day and gave consistent information. Witness Reports and Incident Reports also confirm the details of the incident. RX2.

Following the accident, Petitioner sought treatment in the Emergency Department at Chester Memorial Hospital. He gave a consistent history of the accident and reported a chief complaint of pain in the left hip and groin. He reported he was also punched on his face and head but denied any neck, back, chest, or abdomen pain or injury. Hip and pelvic x-rays were negative for fractures, and brain CT was negative for acute intracranial hemorrhage. Petitioner was instructed to follow up with his primary physician. PX3.

On March 16, 2015, Petitioner followed up with his family physician, Dr. Emily Hanson. He gave a consistent history of the incident and reported he felt a "pop" in his left hip during the altercation. He continued to report pain in his left hip. Dr. Hanson recommended an MRI. PX4.

On March 24, 2015, Petitioner presented to Dr. Nathan Mall at Regeneration Orthopedics. He gave a consistent history of the accident and reported continued pain in his left groin and hip. On examination, Petitioner had pain with resisted hip flexion and some weakness with resisted hip flexion. He also had pain with flexion and internal rotation on the left hip. Dr. Mall's assessment was left hip impingement and possible labral tear. He recommended an MRI arthrogram of the left hip and physical therapy for weakness in hip flexor strength. PX5.

The MRI arthrogram was completed on March 24, 2015, which revealed a full thickness tear of the origin tendon of the left rectus femoris from the left anterior inferior iliac spine, as well as evidence of bilateral gluteus maximus muscle strains, left slightly worse than right. PX6.

On March 27, 2015, Dr. Mall called Petitioner with the results of the MRI. He also indicated he had spoken with the radiologist, who measured about 3 cm of retraction of the rectus femoris tear. He advised this was a somewhat uncommon injury and that surgical intervention was indicated, given Petitioner's age and years of work ahead of him. Surgery was scheduled immediately, due to the fact that the injury was already a month old. PX5.

On March 31, 2015, Petitioner underwent surgical repair of the left rectus femoris avulsion. When the rectus muscle sheath was exposed there was noted to be extreme tension and fluid underneath and there was noted to be substantial scar tissue. The tendon was reattached to the bone. PX7.

Petitioner followed up with Dr. Mall on April 15, 2015. He reported a pulling sensation anteriorly in the hip when he took the brace off. On examination, incisions were healing but Petitioner did have some numbness in the lateral femoral cutaneous nerve distribution. Dr. Mall kept Petitioner in the brace and off work, and started him in physical therapy. PX5.

Petitioner returned to Dr. Mall on May 13, 2015, and reported minimal complaints. On examination, it was noted there was palpable effusion that was getting hard, such as a hematoma, in and around the incision. Petitioner reported it was getting smaller and softer with physical therapy and rubbing the area. He was to continue therapy for stretching. PX5.

Petitioner followed up with Dr. Mall on June 23, 2015, and had minimal complaints and it was noted that physical therapy was progressing nicely. Petitioner continued to have some inflammation in the area of the surgery, but it had lessened since the last visit. Dr. Mall started Petitioner on more aggressive physical therapy for strengthening. PX5.

On July 28, 2015, Petitioner returned to Dr. Mall and reported he was doing extremely well. He had minimal complaints and was progressing with physical therapy. On examination, he still had some inflammation in the area of his surgery but it was improved. He had good quadriceps strength. He was continued in progressive therapy. PX5.

Petitioner returned to Dr. Mall on August 25, 2015, and reported he was doing well and felt he was ready to return to work. He had good strength, sensation, motor function, and hip movement, although there was some stiffness. He was released to return to work full duty. PX5.

On October 13, 2015, Petitioner followed up with Dr. Mall and reported he was doing extremely well. He had been working full duty and had been able to get back in the gym, and was doing well with both. It as noted he was able to lift weights and was back to his normal activities and only had some mild stiffness when putting on his shoes. His physical examination was normal and Dr. Mall released him from care at that time. PX5.

Petitioner testified the surgery improved his condition, but certain activities aggravate his symptoms, such as running and weight lifting. Prior to the accident he ran three miles every other day and now can run about half a mile before his hip hurts and gets inflamed. Prior to the accident he was able to squat between 225 and 400 pounds and now is limited to about 145 pounds. He testified he attempted to squat 225 pounds but it put too much strain and aggravation on his hip so he does not attempt it anymore. He has also noticed that his range of motion is decreased in his left leg as compared to his right leg. Petitioner testified that for 20 years he was a member of Menard's tactical unit, but that he had resigned in September or October 2015 because his hip could not take the strain of the training. He did not lose any pay by resigning, but did lose two hours of comp time for each twice-monthly practice. Petitioner testified he does not take prescription medication for his injury, but does take over the counter Motrin if his hip becomes inflamed or aggravated, which he estimated to be two to three times per week.

CONCLUSIONS OF LAW

The Arbitrator hereby incorporates by reference the Findings of Fact delineated above and the Arbitrator's and parties' exhibits are made a part of the Commission's file. The parties stipulated to all issues, including average weekly wage. The only issue in dispute at the time of trial was the nature and extent of permanent partial disability. With regard to the nature and extent of disability, for accidents occurring after September 1, 2011, pursuant to Section 8.1b of the Act, in determining the level of permanent partial disability the Arbitrator must look at the following five factors.

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

In regard to factor **(ii) the occupation of the injured employee**, the record reveals that Petitioner was employed as a Correctional Lieutenant at the time of the accident and that he was able to return to work in that capacity without any restrictions or limitations as a result of said injury. He did, however, resign from the tactical team which he had been a part of for 20 years, due to the strain on his hip and resulting pain. The Arbitrator notes the physical nature of Petitioner's occupation and places significant weight on this factor.

In regard to factor **(iii) the age of the employee at the time of the injury,** Petitioner was 46 years old at the time of the accident. He has been able to return to his prior position without limitation, although continues to have symptoms. Petitioner can be expected to continue working for a number of years before retiring. Due to the expected time Petitioner will continue to work with symptoms, the Arbitrator places greater weight on this factor.

In regard to factor **(iv) the employee's future earning capacity,** Petitioner has returned to his prior position full duty, with no limitations. Petitioner testified he can no longer serve on the tactical team although he had been a member of same for 20 years. He testified this resulted in the loss of two hours of comp time for each practice. Aside from that, neither party offered any evidence to show that Petitioner's future earning capacity has been impacted, and the Arbitrator has no basis to expect he will have any decreased earning capacity in the future. The Arbitrator places some weight on this factor.

In regard to factor **(v) evidence of disability corroborated by the treating medical records,** the Arbitrator notes that Petitioner sustained a full-thickness retracted rectus femoris tear which required repair through fixation/tendon reattachment. Petitioner's subjective complaints are well-documented in his medical records throughout his treatment. He testified that he still has pain when running, can no longer do heavy squatting, has decreased range of motion in his left leg and hip, and had to resign from the tactical team. Dr. Mall's note following Petitioner's final visit of October 13, 2015, documents he was doing extremely well, had returned to work full duty, had gone back to the gym and was lifting weights, was back to his normal activities, and only had some mild stiffness with putting on his shoes. The Arbitrator places significant weight on this factor.

The Arbitrator notes that consideration of the factors enumerated in Section 8.1b does not simply require a calculation, but rather a measured evaluation of all five factors, of which no single factor is the sole determinant on the issue of permanency. Taking the above five factors into consideration, and based on the record in its entirety, the Arbitrator finds that Petitioner has sustained a 20% loss of use of the left leg (43 weeks) pursuant to Section 8(e) of the Act. The parties stipulated that Petitioner's average weekly wage was $1,833.24. The Arbitrator finds that his permanent partial disability rate is $735.37, which is the statutory maximum rate applicable to his date of accident.

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

Cynthia Nomanson,

17IWCC0012

Petitioner,

vs.

No. 13 WC 03566

YRC, 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 and section 19(l) penalties, 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.[1] The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation, medical benefits or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327 (1980).

Petitioner testified that she worked for Respondent trucking company for 28 years, loading and unloading trucks. She performed the loading and unloading duties manually or using a forklift. Petitioner denied prior injuries or problems with the shoulders.

[1] The Arbitrator's Decision addresses case No. 13 WC 03566 and companion case No. 13 WC 06002. Petitioner filed a petition for review referencing case No. 13 WC 03566 only. In her brief on review, Petitioner likewise only directs her arguments to case No. 13 WC 03566. The Commission therefore modifies the Arbitrator's decision with respect to case No. 13 WC 03566 only.

On December 1, 2012, Petitioner was injured while closing a roll-down trailer door. Petitioner described injuring both shoulders and back while holding onto a strap with one hand and reaching, then grabbing a cable with a hook and trying to pull down a stuck trailer door. Petitioner felt a burning sensation in the shoulders, the left worse than the right, and an ache in the back. Petitioner reported the accident, and a supervisor completed an accident report. A supervisor's injury investigation report in evidence, dated December 1, 2012, describes the mechanism on injury consistently with Petitioner's testimony and notes pain in both shoulders and low back.

Petitioner further testified she was not scheduled to work the next two days. During those two days, the shoulders and back felt sore. When Petitioner returned to work, she was still sore and could not perform her full job duties. Respondent assigned her light duty work.

On December 6, 2012, Petitioner requested medical treatment, and Respondent sent her to Ingalls Occupational Health (Ingalls). Petitioner testified she complained to the Ingalls staff of pain in both shoulders, the left worse than the right. The medical records from Ingalls show that on December 6, 2012, Petitioner presented with complaints of pain in both shoulders and back from pulling a trailer door shut. She was examined by Physician's Assistant Rashonda Collins. Both shoulders were examined. X-rays of the shoulders showed degenerative changes, but "nothing acute." PA Collins prescribed medication and range of motion exercises, and released Petitioner to return to work full duty. On December 13, 2012, Petitioner followed up with Physician's Assistant Megan Dewitt-Dusak, complaining of pain in both shoulders and low back. Petitioner stated her main problem areas were the left shoulder and low back. Both shoulders were examined. PA Dewitt-Dusak diagnosed bilateral shoulder pain, left greater than right, and released Petitioner to return to work on restricted duty. On December 17, 2012, Petitioner saw Dr. Priya Shastri, complaining of bilateral shoulder pain, left greater than right, and low back pain. Petitioner stated her main problem areas were the left shoulder and low back. Dr. Shastri ordered an MRI of the left shoulder and kept Petitioner on restricted duty. The MRI, performed January 2, 2013, showed chronic tendinosis, degenerative changes, and a possible partial thickness tear. On January 4, 2013, Petitioner followed up with PA Collins, complaining of pain in both shoulders and low back. Petitioner stated her main problem areas were the left shoulder and low back. PA Collins reviewed the MRI findings, referred Petitioner to an orthopedic surgeon for the left shoulder, and kept her on restricted duty.

The medical records in evidence further show that on January 10, 2013, Petitioner consulted Dr. John Diveris, an orthopedic surgeon, complaining of pain in both shoulders, the left worse than the right, and low back. She reported a work injury while pulling down a trailer door. On physical examination, Petitioner had tenderness and signs of impingement in both shoulders. Dr. Diveris performed an injection into the left shoulder, prescribed medication and physical therapy, and released Petitioner to return to work on restricted duty. On January 15, 2013, Dr. Diveris released Petitioner to return to work full duty. There is no accompanying clinical note in evidence. Petitioner testified she did not feel significant improvement after the injection, and was in pain all the time.

On January 25, 2013, Petitioner returned to Ingalls. The registration form and handwritten records note complaints of pain in both shoulders and back. Petitioner indicated she reinjured herself/felt pain while "throwing cartons on top of skid." The dictated note, by PA Collins, notes complaints of pain in the left shoulder and low back. The right shoulder was not examined. Petitioner was released to return to work on restricted duty. The staff closed Petitioner's case at her request and transferred her care to her doctor.

Petitioner testified that on January 31, 2013, she "retired" from her job because she "was injured, and [she] didn't think [she] could do it anymore." Petitioner admitted that Respondent offered her light duty work.[2] Petitioner has not worked or looked for work since January 31, 2013.

On March 1, 2013, Petitioner consulted Dr. Joseph Thometz, an orthopedic surgeon. The medical records from Dr. Thometz show Petitioner complained of pain in both shoulders and low back. Dr. Thometz diagnosed bilateral shoulder strain and lumbar strain, and prescribed medication and physical therapy. Petitioner testified the symptoms in the back eventually improved. However, physical therapy aggravated the symptoms in the shoulders. On April 19, 2013, Dr. Thometz noted Petitioner underwent some physical therapy "for her shoulder." Petitioner reported no significant improvement. She also mentioned that in physical therapy she felt "a tingling all the way down into her hand." Dr. Thometz ordered a cervical MRI. The MRI, performed May 26, 2013, showed degenerative changes, a disc osteophyte complex at C4-C5 causing mild effacement of the ventral margin of the thecal sac, and a "severe" broad-based disc bulge at C6-C7 causing no central canal or foraminal narrowing. On June 10, 2013, Dr. Thometz reviewed the cervical MRI results and opined that Petitioner's pain generator was "her shoulder." Dr. Thometz recommended surgery on the left shoulder.

On July 11, 2013, Dr. Thometz performed a left shoulder rotator cuff repair and distal clavicle excision. On August 19, 2013, Dr. Thometz examined the left shoulder and also noted: "She has been having a fair bit of soreness through her right shoulder, particularly pain when she uses it overhead." On September 16, 2013, in addition to complaining of diffuse soreness in the left shoulder, Petitioner complained of increasing pain in the right shoulder. Dr. Thometz modified the physical therapy modalities and kept Petitioner off work. On October 21, 2013, Petitioner similarly complained of diffuse soreness in the left shoulder and continued discomfort in the right shoulder. Dr. Thometz recommended switching physical therapy facilities. On November 11, 2013, Petitioner reported doing better after switching to physical therapy at ATI. However, she complained of a great deal of soreness in the right shoulder. On December 9, 2013, Petitioner reported the right shoulder pain limited some of her physical therapy sessions. Dr. Thometz recommended continuing physical therapy, and kept Petitioner off work. On February 10, 2014, Petitioner reported making progress in physical therapy. However, she complained of a lot of difficulty with the right shoulder. Dr. Thometz prescribed additional physical therapy. On March 10, 2014, Dr. Thometz noted the physical therapist reported

[2] Respondent introduced into evidence a letter to that effect.

significant progress with the left shoulder. However, Petitioner continued to have a lot of pain and limitations with the right shoulder. Dr. Thometz instructed Petitioner to continue physical therapy and kept her off work. During her testimony, Petitioner maintained postoperative physical therapy aggravated her right shoulder condition.

On April 16, 2014, Dr. Bryan Neal, an orthopedic surgeon, examined Petitioner at Respondent's request. Dr. Neal diagnosed a right shoulder adhesive capsulitis unrelated to the work accident. Petitioner testified her right shoulder hurt a great deal when Dr. Neal performed diagnostic maneuvers.

The medical records from Dr. Thometz further show that on April 21, 2014, he noted continued improvement in the left shoulder and continued symptoms in the right shoulder. Dr. Thometz declared Petitioner at maximum medical improvement with respect to the left shoulder condition and ordered an MRI of the right shoulder. The MRI, performed May 21, 2014, was interpreted by the radiologist as showing: "1. Full-thickness tear of the supraspinatus and conjoint tendon resulting in 1.3 x 1.3 cm fluid-filled tear gap at the greater tuberosity footprint with 1.3 cm medial tendon retraction of those tendon components. 2. Tendinosis and myotendinous strain involving the posterior half of the infraspinatus. 3. Medial arch stenosis secondary to distal inferior clavicular spurring and lateral arch stenosis secondary to a markedly downsloped type 2 acromion." On May 23, 2014, Petitioner followed up with Dr. Thometz, who measured the full-thickness supraspinatus tear to be almost 2 cm x 1.5 cm. Dr. Thometz recommended surgery.

Dr. Thometz testified by evidence deposition on June 11, 2015, that during Petitioner's initial visit on March 1, 2013, she had more pain in the left shoulder, but she also had pain in the right shoulder with diagnostic maneuvers. The findings were consistent with the findings of Dr. Diveris. Regarding the cervical MRI, Dr. Thometz testified he ordered it because Petitioner complained of intermittent tingling through her hand and he wanted to ensure that there was not some other source of pathology. The cervical MRI showed no cervical injury or pathology that would correlate with the shoulder complaints.

Dr. Thometz further testified the workers' compensation carrier did not approve the right shoulder surgery. Petitioner continued to regularly follow up for her right shoulder condition. Dr. Thometz last saw Petitioner on April 27, 2015. On May 15, 2015, Petitioner underwent a repeat MRI of the right shoulder, which showed a stable full-thickness supraspinatus tear. Dr. Thometz has kept Petitioner off work.

Regarding causal connection, Dr. Thometz opined the tearing in both the left and the right rotator cuffs was causally connected to the work accident on December 1, 2012. Dr. Thometz continued to recommend surgery on the right shoulder. On cross-examination, Dr. Thometz agreed that on March 1, 2013, Petitioner had chronic tendinopathy in her right rotator cuff. Dr. Thometz also agreed it is possible Petitioner's right rotator cuff tore over time. Dr. Thometz disagreed with the opinion of Dr. Neal that Petitioner's right shoulder condition was

not causally connected to the work accident. Dr. Thometz noted that after the accident, Petitioner consistently complained of pain in the right shoulder. However, the left shoulder was more symptomatic.

Dr. Neal testified by evidence deposition on September 1, 2015, that on physical examination of the right shoulder he noted a painful and reduced range of motion, painful impingement test, positive Speed's test and positive O'Brien's test. The right shoulder was also painful to palpation anteriorly. Dr. Neal initially thought the rotator cuff was intact and "clinically strong," and the examination was consistent with adhesive capsulitis. Dr. Neal diagnosed "resolving adhesive capsulitis with a possible element of rotator cuff tendinopathy or impingement syndrome." Dr. Neal acknowledged that Petitioner "eventually was demonstrated to have a rotator cuff tear." Dr. Neal stated that adhesive capsulitis would not lead to a rotator cuff tear. Dr. Neal opined that "a degenerative chronic process such as impingement is very plausible as a mechanism to cause that tear." In the alternative, Dr. Neal suggested that "it very well may be that [Petitioner] is genetically predisposed to rotator cuff tearing. And so it's not so much the impingement, although she has it, as an intrinsic biologic diathesis for rotator cuff tearing." Dr. Neal maintained that during his examination the right rotator cuff was intact and "strong," and he noted "minimal past right shoulder treatment as of April 16, 2014." Dr. Neal did not find "any right shoulder condition to be causally related to any work incident of December 1, 2012."

Dr. Neal further testified that he reexamined Petitioner on February 15, 2015, and reviewed additional medical records. Dr. Neal acknowledged the right shoulder MRI performed May 21, 2014, showed a full-thickness, retracted rotator cuff tear. At that time, Dr. Neal diagnosed an "improved" adhesive capsulitis, and "she now has an expressed rotator cuff tear." Dr. Neal opined the rotator cuff tear developed sometime after his first examination of Petitioner. Dr. Neal attributed the cause of the rotator cuff tear to "a process which developed over time from the bony degenerative changes and not from any acute rotator cuff tear."

On cross-examination, Dr. Neal agreed the right shoulder surgery would not be unreasonable. However, he maintained it would not be causally connected to the work accident on December 1, 2012. Although Dr. Neal found the left shoulder condition to be causally connected to the accident, he thought it "not very plausible" that Petitioner contemporaneously injured the right shoulder. Rather, Dr. Neal thought Petitioner had right shoulder pain on December 1, 2012, from preexisting adhesive capsulitis. Dr. Neal did not think the accident aggravated a preexisting right shoulder condition. Ultimately, Dr. Neal agreed Petitioner could have had a right full-thickness rotator cuff tear at the time of his first examination on April 16, 2014. Dr. Neal denied the diagnostic maneuvers he performed on that date permanently aggravated Petitioner's right shoulder condition.

Petitioner, during her testimony, denied the pain in the right shoulder ever went away after the accident on December 1, 2012. Petitioner also denied injuring or aggravating the right shoulder between Dr. Neal's examination and subsequent MRI. Petitioner testified the right

shoulder hurts all the time, which prevents her from doing much with her right arm. Petitioner denied being released to return to work at any time after July 11, 2013.

The Arbitrator found that Petitioner sustained injuries to her shoulders and low back, and the right shoulder condition reached maximum medical improvement on or before December 13, 2012, while the left shoulder and low back conditions reached maximum medical improvement by April 21, 2014. The Arbitrator awarded temporary total disability benefits from July 11, 2013, through April 21, 2014, and medical benefits as follows: "The medical care rendered the petitioner for her left shoulder and low back through April 21, 2014, was reasonable and necessary and is awarded. The medical care rendered the petitioner for her right shoulder and cervical spine and for her left shoulder after April 21, 2014, was not reasonable and necessary and is denied."

The Commission disagrees with the Arbitrator regarding causation/maximum medical improvement of the right shoulder condition. The evidence shows Petitioner consistently complained of right shoulder pain after the work accident on December 1, 2012. On January 10, 2013, Dr. Diveris noted signs of impingement in both shoulders. On March 1, 2013, Dr. Thometz likewise noted signs of impingement in both shoulders. Because the left shoulder was more symptomatic, the treatment focused on the left shoulder. The right full-thickness rotator cuff tear was not discovered until May 21, 2014. Without the benefit of an MRI, Dr. Neal misdiagnosed the right rotator cuff tear as adhesive capsulitis. During his deposition testimony, Dr. Neal stuck to his diagnosis of adhesive capsulitis. The Commission is not persuaded by Dr. Neal's diagnosis of preexisting adhesive capsulitis or his causal connection opinion, given Petitioner's work history, description of the mechanism of injury and resultant pain in the right shoulder. The Commission notes the mechanism of injury and resultant pain in the right shoulder are corroborated by the supervisor's report and contemporaneous medical records. The Commission relies on the chain of events and the opinion of Dr. Thometz to find the right shoulder condition is causally connected to the work accident on December 1, 2012.

Accordingly, the Commission finds Petitioner is entitled to: temporary total disability benefits from July 11, 2013, through the date of the arbitration hearing on December 17, 2015; payment of related medical bills in evidence pursuant to sections 8(a) and 8.2 of the Act; and prospective medical care in the form of surgery and attendant care for the right shoulder condition. Regarding causal connection and necessity of the cervical MRI, the Commission finds it causally related and diagnostically necessary, given the mechanism of injury and Petitioner's complaints of shoulder pain and intermittent tingling through her hand.

Lastly, the Commission notes that in the request for hearing form Respondent claimed credit for "all bills paid by group [medical plan]." To the extent any such payments were made, Respondent is entitled to a credit, provided Respondent holds Petitioner harmless from any claims and demands by any providers of the medical benefits.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 4, 2016, is hereby modified as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $646.08 per week for a period of 127 1/7weeks, from July 11, 2013, through December 17, 2015, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation, medical benefits or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay related medical bills in evidence pursuant to §§8(a) and 8.2 of the Act. To the extent any payments were made by a group medical plan, Respondent is entitled to a credit, provided Respondent holds Petitioner harmless from any claims and demands by any providers of the medical benefits.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall provide prospective medical care in the form of surgery and attendant care for the right shoulder condition, pursuant to §§8(a) and 8.2 of the Act.

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

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

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

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

JAN 18 2017

DATED:
o-12/15/2016
SM/sk
44

Stephen J. Mathis

Stephen Mathis

Mario Basurto

David L. Gore

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

NOMANSON, CYNTHIA
Employee/Petitioner

Case# **13WC003566**

13WC006002

YRC INC
Employer/Respondent

17IWCC0012

On 2/4/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

1641 LAW OFFICES OF JOHN L DRUMM
15255 S 94TH AVE
SUITE 500
ORLAND PARK, IL 60462

0766 HENNESSY & ROACH PC
SUSAN E WALSH
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)

17IWCC0012

ILLINOIS WORKERS' COMPENSATION COMMISSION

19(b) ARBITRATION DECISION

CYNTHIA NOMANSON
Employee/Petitioner

Case #13 WC 3566
#13 WC 6002

V.

YRC, INC.,
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Robert Williams, arbitrator of the Workers' Compensation Commission, in the city of Chicago, on December 17, 2015. After considering all of the issues, the stipulations of the parties and the evidence, it is hereby found and ordered as follows:

ISSUES:

A. ☐ Was the respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?

B. ☐ Was there an employee-employer relationship?

C. ☐ Did an accident occur that arose out of and in the course of the petitioner's employment by the respondent?

D. ☐ What was the date of the accident?

E. ☐ Was timely notice of the accident given to the respondent?

F. ☒ Is the petitioner's present condition of ill-being causally related to the injury?

G. ☐ What were the petitioner's earnings?

H. ☐ What was the petitioner's age at the time of the accident?

I. ☐ What was the petitioner's marital status at the time of the accident?

J. ☒ Were the medical services that were provided to petitioner reasonable and necessary?

K. ☒ What temporary benefits are due: ☐ TPD ☐ Maintenance ☒ TTD?

L. ☒ Should penalties or fees be imposed upon the respondent?

M. ☐ Is the respondent due any credit?

N. ☒ Prospective medical care?

FINDINGS

- On December 1, 2012, and January 25, 2013, the respondent was operating under and subject to the provisions of the Act.

- On those dates, an employee-employer relationship existed between the petitioner and respondent.

- On December 1, 2012, the petitioner sustained injuries that arose out of and in the course of employment.

- Timely notice of the accidents was given to the respondent.

- In the year preceding the injuries, the petitioner earned $50,394.24; the average weekly wage was $969.12.

- At the time of injuries, the petitioner was 53 years of age, married with no children under 18.

- The petitioner agreed that the respondent paid $25,660.20 in temporary total disability benefits.

ORDER:

- The respondent shall pay the petitioner temporary total disability benefits of $646.09/week for 40-5/7 weeks, from July 11, 2013, through April 21, 2014, which is the period of temporary total disability for which compensation is payable. The respondent is given an offset for the $25,660.20 it paid in temporary total disability benefits.

- The medical care rendered the petitioner for her left shoulder and low back through April 21, 2014, was reasonable and necessary and is awarded. The medical care rendered the petitioner for her right shoulder and cervical spine and for her left shoulder after April 21, 2014, was not reasonable and necessary and is denied. The respondent shall pay the medical bills in accordance with the Act, the medical fee schedule or any prior adjustments or negotiated rate. The respondent shall be given credit for any amount it paid toward the medical bills, including any amount paid within the provisions of Section 8(j) of the Act and shall hold the petitioner harmless for all the medical bills paid by its group health insurance carrier.

- The petitioner's request for a right shoulder arthroscopic rotator cuff repair is denied.
- The petitioner's request for penalties and fees is denied.
- The petitioner's request for benefits for claim #13 WC 6002 is denied and the claim is dismissed.
- 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 4, 2016

Date

FEB 4 - 2016

FINDINGS OF FACTS:

The petitioner, a dock worker, sustained an injury on December 1, 2012. The incident is the subject matter of claim #13 WC 3566. She sought care for low back and bilateral shoulder pain at Ingalls Occupational Health on December 6th and reported her injury occurred pulling a trailer door shut on December 1st. X-rays of her shoulders revealed degenerative changes and no acute changes. Mild tenderness to palpation of her shoulders was noted. There was no tenderness to palpation of her cervical and lumbar spines. The diagnosis was bilateral shoulder and low back pain. She was advised to take Ibuprofen as needed and was released to full-duty work. On December 13th, the petitioner complained of moderate-to-severe, stabbing left shoulder pain and aching lower back pain. She was released to light-duty work with no lifting or carrying greater than 10 lbs and minimal use of her left hand and arm. On December 17th, the petitioner complained of continued intermittent left shoulder pain and aching lower back pain. The petitioner began physical therapy on December 18th. An MRI of her left shoulder on January 2nd revealed no full-thickness rotator cuff tear, chronic tendinosis, moderate scattered degenerative changes with bone marrow changes and subchondral cysts, and the possibility of a partial-thickness tear of the biceps tendon. The petitioner's complaints were unchanged on January 4, 2013. The petitioner saw Dr. Diveris at Diveris Orthopedic & Sports Medicine on January 10th, who gave her a cortisone injection into her left subacromial space. On January 15th, Dr. Diveris released the petitioner to work without restrictions.

On January 25th, the petitioner returned to Ingalls and reported a re-injury to her left shoulder and low back at work that day while performing overhead work. The matter

is the subject of claim #13 WC 6002. The diagnosis was left shoulder and bilateral low-back pain. She was given 15-pound lifting and carrying restrictions and minimal overhead work with her left arm. On January 31st, the respondent offered to accommodate the petitioner's restrictions, which was accepted but she then retired.

Dr. Thometz evaluated the petitioner on March 1st and opined that the MRI didn't show any pathology warranting surgery, only some longitudinal tearing of the biceps that did not correlate with her symptoms. Physical therapy was started. She reported little improvement in her shoulder on April 19th, a lot of discomfort through the posterior aspect of her left shoulder, a tingling down to her hand with manipulation of her scapula in therapy and the return of her low-back symptoms. The doctor noted that his exam revealed full forward elevation without too much discomfort, tenderness through the posterior border of the scapula and some pain with end range cervical rotation. Dr. Thometz recommended a cervical MRI and physical therapy for her left shoulder and neck. A cervical MRI on May 26th revealed normal vertebral body heights with degenerative changes, a cervical core with no gross abnormal signal, a disc osteophyte complex at C4-5 with mild effacement of the ventral margin of the thecal sac, a severe broad-based disc bulge at C6-7 and a patent central canal.

Dr. Thometz recommended shoulder surgery on June 10th and performed a left shoulder arthroscopic debridement of a type I labrum, a rotator cuff repair, a subacromial decompression and a distal clavicle excision on July 11th. The post-operative diagnosis was high-grade partial tear of the rotator cuff, AC joint arthropathy and a type I labral tear of the left shoulder. Physical therapy was prescribed on July 22nd and started on July

25th. Dr. Thometz noted progressive improvement and improved range of motion at monthly follow-ups through December 9th.

On February 10, 2014, the petitioner reported that she was having a lot of difficulty with her right shoulder and on March 10th, she complained of a lot of pain and restrictions with her right shoulder. The doctor noted significant improvement with her left shoulder range of motion. At the respondent's request, Dr. Neal evaluated the petitioner on April 16th. He noted a normal range of motion of her cervical spine, intact rotator cuffs and positive impingement, Speed's and O'Brien's tests on her right. His assessment was resolving left and right shoulder adhesive capsulitis and chronic, non-radicular low back pain. Dr. Thometz noted improvement in both shoulders on April 21st. The doctor discharged her from therapy and noted that she had satisfactorily recovered from her left shoulder injury.

An MRI of her right shoulder on May 21st revealed a full-thickness tear of the supraspinatus and a conjoined tendon resulting in a fluid-filled gap tear at the greater tuberosity footprint with medial tendon retraction of those components, tendinosis and myotendinous strain involving the posterior half of the infraspinatus, a medial arch stenosis secondary to distal inferior clavicular spurring and a lateral arch stenosis secondary to a markedly down-sloped type II acromion. On May 23rd, Dr. Thometz opined that the right shoulder MRI revealed a full-thickness tear of the supraspinatus with retraction of almost 2 centimeters and an anterior-to-posterior displacement about 1 to 1-1/2 centimeters, moderate AC joint arthropathy causing some impingement, a mild curvature of the acromion and no remarkable muscular atrophy or apparent labral tear.

The doctor recommended an arthroscopic right rotator cuff repair at follow-ups through December 29th.

The petitioner was reevaluated by Dr. Neal on February 5, 2015. Dr. Neal noted a symmetrical passive range of motion for her shoulders, painful right AC joint and supraspinatus, positive Hawkins and O'Brien's tests on the right and an impingement sign. He opined that the petitioner had a right rotator cuff tendinopathy and impingement consistent with a rotator cuff tear.

FINDING REGARDING WHETHER THE PETITIONER'S ACCIDENT AROSE OUT OF AND IN THE COURSE OF HIS EMPLOYMENT WITH THE RESPONDENT:

Based upon the testimony and the evidence submitted, the petitioner failed to prove that she sustained an accident on January 25, 2013, arising out of and in the course of her employment with the respondent. There is no evidence of a trauma, accident or injury on January 25, 2013. The petitioner's complaint of a re-injury to her left shoulder and low back on January 25, 2013, while performing overhead duties at work is not sufficient to establish an accident arising out of or in the course of her employment with the respondent. The petitioner's request for benefits for claim #13 WC 6002 is denied and the claim is dismissed.

FINDING REGARDING WHETHER THE MEDICAL SERVICES PROVIDED TO PETITIONER ARE REASONABLE AND NECESSARY:

The medical care rendered the petitioner for her left shoulder and low back through April 21, 2014, was reasonable and necessary and is awarded. The medical care rendered the petitioner for her cervical spine and for her left shoulder after April 21, 2014, was not reasonable or necessary and is denied. Dr. Thometz discharged the

petitioner on April 21, 2014, and noted that she had satisfactorily recovered from her left shoulder injury.

The medical care rendered the petitioner for her right shoulder after December 13, 2012, was not reasonable or necessary and is denied. The petitioner did not complain of right shoulder symptoms after her initial care on December 6, 2012, through February 10, 2014.

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 left shoulder and low back is causally related to the work injury on December 1, 2012.

The petitioner failed to prove that her current condition of ill-being with her right shoulder and cervical spine is causally related to a work injury. The petitioner did not report a cervical injury, she did not have any neck symptoms and the initial medical examination did not reveal any tenderness to palpation of her cervical spine. She was released to work without restrictions on January 15, 2013. The petitioner did not have any right shoulder symptoms after her initial care on December 6, 2012, through February 10, 2014, when she reported difficulty with her right shoulder.

FINDING REGARDING THE AMOUNT OF COMPENSATION DUE FOR TEMPORARY TOTAL DISABILITY:

The petitioner was unable to work from July 11, 2013, through April 21, 2014. The respondent shall pay the petitioner temporary total disability benefits of $646.09/week for 40-5/7 weeks, from July 11, 2013, through April 21, 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 failed to prove that the right shoulder arthroscopic rotator cuff repair recommended by Dr. Thometz is reasonable medical care necessary to relieve the effects of the work injury. The petitioner's request for a right shoulder arthroscopic rotator cuff repair is denied.

FINDING REGARDING PENALTIES AND FEES:

The petitioner failed to prove that she is entitled to §19(l) and §19(k) penalties and fees. The evidence was insufficient to establish that the respondent's delay in the payment of temporary total disability benefits was without a good and just cause or that their conduct was vexatious and unreasonable. There was a genuine dispute regarding the issues of the causal connection of her condition of ill-being with her cervical spine and right shoulder, accident and her entitlement to temporary total disability benefits. The petitioner's request for penalties and fees is denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF ROCK ISLAND)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Amy G. Clark,

Petitioner,

vs. No. 14 WC 10723

17IWCC0013

Resthave Retirement & Nursing Home,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical expenses, prospective medical care, temporary disability and motion for determination of fraud, 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 compensation for permanent disability, if any, and any other proceedings consistent with this decision, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327 (1980).

On April 1, 2014, Petitioner filed an application for adjustment of claim alleging that on or about January 14, 2014, she sustained accidental injuries to her "right knee, hip, back, neck and person as a whole" when she fell on some ice while taking out the garbage. Petitioner, a 38 year old certified nursing assistant (CNA) at the time of the accident, testified at the arbitration hearing that she began working for Respondent in 2012. Her job was to care for elderly patients. The job duties included bathing, dressing and feeding the patients, controlling combative patients, and doing the laundry. Petitioner further testified that she contemporaneously worked as a CNA for a private client.

On January 14, 2014, near the end of the shift, Petitioner fell on an icy sidewalk while taking out the garbage. Petitioner elaborated: "I fell to my right side. I fell first on my knee then to my side and my back." Petitioner affirmed the first impact was to the front of the knee.

Petitioner promptly sought treatment for her injuries. The medical records from Morrison Community Hospital show that on January 14, 2014, Petitioner presented at with complaints of pain in the right knee and back, and stiffness in the neck. The attending physician, Dr. Duncan Dinkha, noted the following mechanism of injury: "Today she was taking the trash out and she slipped on the ice and she fell down on her back." The nurse's notes also mention a pop in the right knee. X-rays of the right knee showed no evidence of acute traumatic injury. Dr. Dinkha diagnosed muscular strain of the lower and mid back, and right knee sprain. He prescribed Relafen and Norco and took Petitioner off work through January 21, 2014.

The medical records further show that on January 21, 2014, Petitioner followed up at Medical Associates/Morrison Family Health Clinic, complaining of pain in the back and right knee. Petitioner saw Physician's Assistant Brian Glasz. Physical examination was limited due to Petitioner's pain complaints. X-rays of the lumbar spine showed "[m]ild disk height loss at L5-S1 likely from degenerative change. Nothing acute." PA Glasz prescribed ibuprofen, Flexeril and physical therapy, and took Petitioner off work through February 4, 2014.

On January 22, 2014, Petitioner had a primary care visit with Dr. Kelley Guthrie at Whiteside County Community Health Clinic. Petitioner mentioned a right knee injury that was being treated under workers' compensation.

On January 28, 2014, Petitioner followed up with PA Glasz, complaining of persistent back and right knee pain. PA Glasz noted the following mechanism of injury: "[O]n 14 January *** she slipped on ice while [carrying] 2 bags of trash she states she slipped, fell, landed on her knee, buttocks and right-sided back." Physical examination of the back was notable for tenderness to palpation. Examination of the knee was unremarkable, with the exception of some pain with end range of motion and some tenderness over the prepatellar bursa. PA Glasz performed an injection into the knee. On February 4, 2014, Petitioner reported the injection helped significantly. She also reported continued right-sided flank pain. PA Glasz noted that Petitioner's medications at the time included: Ambien, Celexa, clonazepam, cyclobenzaprine, ibuprofen, Levothroid, Naproxen, Norco, omeprazole, prazosin, Ritalin, tramadol and trazodone. PA Glasz further noted Petitioner was approved to start physical therapy the following Monday. He released Petitioner to return to work on restricted duty.

On February 10, 2014, Petitioner underwent an initial evaluation at Rock Valley Physical Therapy. The physical therapist noted the following: "[The patient] complains of a back injury sustained while at work on 1.14.14. She works for [Respondent] as a CNA and was carrying garbage out to the dumpsters and slipped and fell on the ice. She twisted her right knee and fell down on the right side. Received a cortisone injection in the knee which has helped a lot (1.5 weeks ago). Is taking pain meds, when she can – doesn't take them when she is working or

having to drive. Was off work for 3 weeks and was then released to light duty. When she returned was doing more than she was comfortable with and was in more pain. *** Was told that she had a muscle strain. Light duty – feeding people, re-arranging closets, etc. Has not returned to work (has called off) due to increased back pain. *** Pain is mostly in the right low back down the posterior thigh but does have some pain in the neck and knee." The physical therapist was unable to perform joint integrity and mobility testing "due to pt's tenderness with light palpation of lumbar musculature." The physical therapist further noted: "Pt. stands with weight primarily on the left with the right knee flexed. When prompted to even out her weight, she is unable to perform due to increased LBP on the right with increased WB. In supine, the right knee is once again flexed with inability to straighten due to anterior knee pain. With performing supine SLR testing, the knee is able to reach almost full extension once the leg is lifted – increasing LBP with this motion." The physical therapist recommended six weeks of therapy.

On February 12, 2014, the physical therapist noted: "Pt. able to move a little easier today and her right knee had full extension without complaints of pain." On February 14, 2014, Petitioner reported persistent back pain. She also reported having worked two shifts on light duty and being in a lot of pain. The physical therapist noted: "Patient exhibits moderate atypical pain behavior in response to therapeutic activity performed during today's visit." The physical therapist further noted: "Pt. was unable to fully extend the right knee in supine today due to increased pain, although she was able to perform this task on our last session. She is able to attain full knee extension bilaterally with standing and ambulation."

Also on February 14, 2014, Petitioner saw Dr. Guthrie for a "second opinion" regarding her work injuries. Petitioner's main complaint was pain in the mid and low back. Dr. Guthrie ordered: a lumbar MRI due to "pain radiating from lumbar back through sciatic nerve distribution, down right leg;" a cervical MRI due to "referred pain noted to right neck scapula and right shoulder, decreased ROM;" and a right knee MRI due to "reflex absent on physical exam, concern re: damage to ACL vs. meniscal tear." Petitioner also complained of pain in the right shoulder. Dr. Guthrie ordered a thoracic MRI as well. Dr. Guthrie noted: "[P]t currently unable to lift her grandchild and/or perform duties at work."

On February 19, 2014, Petitioner reported to the physical therapist she had not worked since the last physical therapy session. She complained of persistent, significant pain, for which she was taking Vicodin and muscle relaxants. The physical therapist continued to note atypical pain behavior, and further noted: "Pt. was able to attain full knee extension without complaint of pain. SLR while pt. was distracted was WNL." On February 21, 2014, Petitioner tolerated physical therapy with moderate complaints of pain and difficulty. On February 24, 2014, Petitioner reported "she felt good for a few days until she did too much cleaning on Sunday and is sore again today." Petitioner tolerated physical therapy with mild complaints of pain and difficulty. On February 26, 2014, the physical therapist noted: "Pt. states that she has felt a little worse over the past few days – tried to do more around the house yesterday." Again, Petitioner tolerated physical therapy with mild complaints of pain and difficulty. On February 28, 2014, the physical therapist noted: "Stiff and sore today. Woke up at midnight and took pain meds and

was not able to get comfortable all night – in worse pain today (8/10). Did not do anything different yesterday. States that MRI was approved." Petitioner then voiced severe complaints of pain and difficulty with physical therapy, which caused the physical therapist to end the session early.

On March 5, 2014, Petitioner followed up with Dr. Guthrie, who charted the following: "**Low back pain with sciatica** (724.3) pain extends up through cervical and thoracic spine, pt. unable to bend, recommend pending MRI's and eval for spinal block, pt. currently requiring high dose narcotics and muscle relaxants which will not be able to continue indefinitely, hopeful eval to Dr. Ibarra, pt. currently on W/C, unable to return to provide CNA services. **Neck pain on right side** (723.1) pt. has limited mobility and chronic pain. **Right knee pain** (719.46) pt. walking with limp. **Right shoulder pain** (719.41) pt. unable to lift. **Morbid obesity, BMI 40 or more**." (Emphasis in original.) Physical examination was normal, however. Dr. Guthrie did not comment on the discrepancy between Petitioner's subjective complaints and physical examination findings.

On March 13, 2014, Petitioner underwent MRI studies of the cervical and lumbar spine and the right knee. The cervical MRI showed "[m]oderate diffuse disk bulging at C6/C7 with possible central disk protrusion causing mild central spinal stenosis." The lumbar MRI showed: "1. Mild degenerative disk changes noted L5-S1 and minimally at L4-L5 levels with mild diffuse bulging of the annulus without any significant central spinal canal stenosis or neural foraminal compromise. 2. Rest of the lumbar spine is unremarkable. 3. Mild degenerative facet changes are seen at L4-L5 and L5-S1 levels." The right knee MRI showed: "1. Chronic-appearing meniscal capsular separation with adjacent loculated fluid. 2. Osteoarthritic changes of the patellofemoral joint. 3. Small joint effusion."

On March 18, 2014, Petitioner followed up with Dr. Guthrie, complaining of low back pain with urinary incontinence and neck pain with cervical neuropathy. Dr. Guthrie referred Petitioner to a neurosurgeon. On March 20, 2014, Dr. Guthrie took Petitioner off work "until she is released from [Dr. Guthrie's] care."

On May 2, 2014, Petitioner returned to Dr. Guthrie, who noted: "[P]t reports all extr. go numb throughout day, which would be consistent with nerve compression of both cervical and lumbar sacral nerve compression. right knee and low right back give out and collapse with minimal use." With respect to the back pain, Petitioner reported she was taking Vicodin "during the day and at night. Vicodin is not helping." The staff further noted: "[P]t states take Naproxen, IB, Vicodin during day for pain. c/o pain medications have not been helping much any more." Petitioner also reported no improvement in her right shoulder condition. With respect to the right knee, Petitioner complained the pain radiated to the right ankle, and the foot would fall asleep. During physical examination, Petitioner had "difficulty getting up onto exam table/appears to be in pain sitting." Pertinent physical examination findings were as follows: "[P]ain occurring right shoulder at less than 90 degrees angle. left shoulder 80% degree angle. 45% ability to turn head to left, and to turn head right is 30% with lateral gaze. right arm weak

against mild resistance, left arm is weak but better than right. left peripheral finger tips resistance is intact and normal, right is intact but weaker. right grip is weaker than left. direct pain over cervical, thoracic and lumbar spine. knee pain felt at approx 45% right leg raise with cont sciatica pain before 90%, straight leg raise is minimal on left side." Dr. Guthrie issued a letter stating: "[The patient] is currently under my medical care and may not return to work under her usual capacity. She cannot complete patient care, lift anything more than 10#, or able to do long standing or walking. She may do paperwork in a sitting position until further notice."

On May 30, 2014, Petitioner returned to Dr. Guthrie. The note is uncharacteristically brief, mentioning complaints of "back pain, neck pain, right knee pain." Dr. Guthrie charted that back and neck pain was "stable," and referred Petitioner to an orthopedic surgeon for the right knee pain. Dr. Guthrie took Petitioner off work until an evaluation by an orthopedic surgeon.

On June 20, 2014, Petitioner consulted Dr. Raymond Hwang at Midwest Orthopaedic Institute for a spinal evaluation. Dr. Hwang noted the following history and complaints: "The patient reports that her symptoms began at work on 1/14/14. She reports carrying garbage in her hands and while walking to the dumpster when she slipped and fell on ice, landing on her right knee and then her low back. The patient reports acute onset of symptoms at that time, including right-sided posterior neck pain where there is soreness and throbbing, as well as right-sided low back pain where there is throbbing pain. The patient reports that she has extension of right low back pain into her right buttock and her right lateral thigh. She also experiences intermittent numbness involving the right upper extremity. She localizes these symptoms to the lateral upper arm, radial forearm and to the radial digits of her right hand. This occurs after approximately 10 minutes of activity with the right upper extremity. The patient feels better when she is resting and supine. She feels worse when she is standing and walking with activity. *** She reports a four-month history of urinary urgency, particularly at night, but denies any urinary retention or incontinence. *** The patient reports difficulty using her right hand when it is numb but otherwise denies any difficulty or clumsiness with fine motor skills. She denies any difficulty with walking or balance, although she reports that she has significant right knee pain from her accident that does affect her walking. *** Her right thigh pain is a 9/10. Her back pain is an 8 to 9/10, which is her primary complaint. *** Her neck pain is an 8/10."

Dr. Hwang noted that Petitioner ambulated "with a stable, antalgic gait secondary to low back pain and right knee pain." Physical examination findings were as follows: "She is able to perform tandem gait, heel-and-toe walking as well as heel-to-shin test. She demonstrates 60 degrees of cervical flexion and extension, 60 degrees of bilateral rotation and 45 degrees of bilateral bend, with reproduction of her neck pain on left bend. She has mild tenderness to palpation along the midline of the posterior cervical spine. She does not appear to be in spasm. She has a negative Spurling's sign and a negative Lhermitte's sign. She demonstrates 90 degrees of lumbar flexion with reproduction of her low back pain on flexion, and 20 degrees of extension without pain. She has significant tenderness to palpation along the right paraspinal musculature of the low lumbar spine. She has no spasms. She has a negative straight leg raise and she is warm and well perfused in the bilateral lower extremities. She has no pain with passive range of

motion of the hips. She has a positive bilateral FABER sign. She has 5/5 symmetric strength in her bilateral trapezius, deltoids, biceps, triceps, finger flexors, finger abductors and adductors, hip flexors, quadriceps, tibialis anterior, extensor hallucis longus and gastrocsoleus. She has 1+ bilateral and symmetric biceps, brachioradialis, triceps, patellar and Achilles reflexes, a negative Hoffmann's sign, a negative Babinski sign and no sustained clonus bilaterally. Sensation to light touch is intact throughout the bilateral upper and lower extremities today."

Dr. Hwang noted the MRI studies showed cervical and lumbar spondylosis. Dr. Hwang opined: "The patient's right upper extremity symptoms are most suggestive of a C6 dermatome. This does not correlate precisely with the patient's MRI findings. The patient's right upper extremity symptoms are activity related and secondary to her primary complaint of low back pain." Dr. Hwang discussed cervical spine surgery, which Petitioner declined. Dr. Hwang therefore recommended interventional pain management and physiatry treatment. On July 1, 2014, Petitioner began treating with Dr. Jacinthe Malalis, a physiatrist. Dr. Malalis recommended physical therapy, medication and injections.

On July 30, 2014, Petitioner consulted Dr. Russell Bodner at Midwest Orthopaedic Institute regarding her right knee. Dr. Bodner noted: "She describes an injury in January of this year where she fell while carrying two garbage bags, one in each arm, striking the front of her knee on the icy ground and then falling onto her right side. *** She has had persistent pain, swelling, popping and warmth in the knee, since that time. *** She has been found on workup to have an arthritic condition in her knee without acute internal derangement. Presently she rates her pain as high as 8/10 and states the pain is constant. It is worse with activity. *** She is a CNA and has not been back at work because of this injury." On physical examination, Dr. Bodner noted a reduced range of motion in the right knee and crepitus in both knees. Dr. Bodner reviewed the MRI, noting "[t]he principal finding is advanced patellofemoral chondromalacia and early arthritic change. There is also arthritic change in the medial compartment and some laterally, though it is small." Dr. Bodner opined that Petitioner "had a direct blow on the front of her knee when she fell, exacerbating the underlying patellar chondromalacia and early arthritis. * * * [I]t is my feeling that this injury [has] seriously exacerbated the underlying significant chondromalacia and it has in fact put her over the edge from recovering." Dr. Bodner performed an injection into the knee and released Petitioner to return to work on sedentary duty.

On September 2, 2014, Petitioner followed up with Dr. Malalis, who noted: "The patient continues to experience a constant, achy, and intermittent sharp pain localized to the right side of her low back, worse with prolonged sitting, standing, and lying down on her right side, and it is improved with lying [on] her left side. *** She reports an intermittent right lower extremity numbness that she describes goes into her posterior thigh. *** She continues to have a constant, achy pain localized to the right side of her neck ***. She also reports intermittent numbness and tingling into the right elbow." Petitioner stated she had not started physical therapy because the local physical therapy locations did not accept her insurance. Dr. Malalis recommended lumbar facet injections. On September 4, 2014, Dr. Malalis performed the injections.

On September 24, 2014, Petitioner followed up with Dr. Bodner, reporting the knee injection helped for only four weeks. Dr. Bodner noted: "The pain is back in the anterior knee with radiation down the leg. She has popping, swelling and occasionally the knee will give out on her." Physical examination was notable for some puffiness, pain and crepitus. Dr. Bodner discussed viscosupplementation and partial knee replacement, and took Petitioner off work. On October 27, 2014, Petitioner followed up with Dr. Bodner, who noted: "The injections that I gave her have worn off and she is in constant pain which shoots down her leg. She is tripping a lot and complains of some numbness going down toward her foot. She states that about one to two weeks ago, when she was carrying towels after washing her house, her knee gave out and she fell forward and struck the ground." On physical examination, Dr. Bodner noted some mild residual bruising. Physical examination was also notable for patellofemoral crepitus bilaterally, as well as medial tenderness and mild pain on valgus stress. Dr. Bodner continued to recommend viscosupplementation or surgery.

Also on October 27, 2014, Petitioner followed up with Dr. Malalis, reporting the back pain returned a month and a half after the facet injections. Dr. Malalis noted: "She describes a constant, dull, sharp pain that radiates from the right side of her low back to her right-sided mid back and up to her neck, worse with prolonged standing and walking and improved with lying down on her left side. *** She also reports numbness and tingling in the right foot. *** She reports weakness in the right leg as well as in the low back. She also reports tripping and urinary stress incontinence." Dr. Malalis continued to recommend physical therapy. On December 9, 2014, Petitioner did not show for her appointment with Dr. Malalis. There are no further notes from Dr. Malalis in the record.

On February 16, 2015, Petitioner followed up with Dr. Bodner, complaining of worsening pain in the knee. Dr. Bodner's opinions and recommendations remained unchanged. On April 13, 2015, Petitioner followed up with Dr. Bodner, complaining of severe pain. Dr. Bodner noted: "She has gone to walking with a cane. Her knee tends to give way. *** Overall, she still states that her pain is anteriorly based." Physical examination findings were as follows: "[H]er knee flexes to about 110 degrees with anterior crepitus. She has stable ligaments. There is no redness, rash or sign of infection, cellulitis or bursitis. Her calf is soft. Her distal neurovascular examination is intact. Her Homan's sign is negative." Dr. Bodner continued to recommend a partial knee replacement. He kept Petitioner off work.

On May 14, 2015, Petitioner sought emergency treatment at St. Elizabeth Medical Center for right knee pain. The emergency room nurse charted the following: "[The patient] [p]resented to ED with complaints of right knee pain. Patient states she has had this pain since winter time when she slipped on ice at her job. Patient states she is on worker's compensation. Patient was in Utica at water park and she was swimming when it aggravated her knee pain." The attending physician charted the following: "The incident occurred more than 2 days ago. The incident occurred at the pool. There was no injury mechanism. The pain is present in the right knee. The pain is at a severity of 4/10. The pain is moderate. The pain has been constant since onset." Petitioner did not voice any complaints of neck or back pain. Physical examination of the neck

was unremarkable. It is unclear whether examination of the back was performed. Physical examination of the right knee was notable for diffuse tenderness and effusion. The attending physician prescribed Percocet and discharged Petitioner home.

On May 18, 2015, Petitioner followed up with Dr. Bodner, who noted the following: "She states that she was in a water park in Ottawa on Thursday evening to see if she could get some exercise in the water. She had severe pain requiring her to go to an OSF hospital in Ottawa. She was evaluated and given some Percocet, which helped her. Her pain is in the anterior aspect of her knee. She has used ibuprofen and naproxen without help and she is using a cane. She states that she has swelling and warmth." Physical examination findings were as follows: "[S]he has a slight bruise above the patella. There is no redness, rash or sign of infection, cellulitis or bursitis. She has a range of motion to 90 degrees with some mild crepitus on flexion. Her ligamentous stability is otherwise intact. Her calf is soft. Her distal neurovascular examination is intact." Dr. Bodner ordered a repeat MRI and weightbearing X-rays. Petitioner requested pain medication. Dr. Bodner referred her to "her local doctor or a pain clinic."

On May 20, 2015, Petitioner underwent a repeat MRI of the right knee, which showed the following: "1. Moderate mucinous degeneration and laxity throughout the anterior cruciate ligament and involving the anterior horn root insertion lateral meniscus with small subjacent degenerative ganglion cyst in the tibial plateau and moderate size ganglion cyst at the proximal attachment. 2. Marked central lateral patellofemoral compartment osteoarthritis. 3. Moderate partial thickness cartilage loss in the medial and lateral compartment without unstable meniscus tear. 4. Moderate-sized deep medial collateral ligament bursitis containing multiple septations measures 5.0 x 3.3 x 0.8 cm in size. 5. Moderate-sized joint effusion. Mild pretibial subcutaneous edema."

On June 3, 2015, Petitioner followed up with Dr. Bodner, who noted: "[The patient] is tearful today and states she is in pain every day. She cannot work. She cannot help to take care of her family or play with her grandchild. Her pain is mostly anterior and she does have some radiation up toward her hip on her right side." Physical examination findings were as follows: "[S]he has a heavy knee. She has good range of motion. She has tenderness to palpation anteriorly. She has patellofemoral crepitus. She has medial joint line tenderness and some tenderness over the proximal medial tibia. Her calf is soft. Her Homan's sign is negative." Dr. Bodner reviewed the MRI findings and also noted that X-rays showed early degenerative change in the medial compartment with articular cartilage loss and patellofemoral articular cartilage loss. Dr. Bodner's causal connection opinion remained unchanged.

Dr. Bodner testified by evidence deposition on July 6, 2015, that on July 30, 2014, he put Petitioner on sedentary duty out of concern her job would exacerbate the pain. During the next visit, Dr. Bodner took Petitioner off work because Petitioner must have indicated that Respondent had no sedentary work available. Dr. Bodner maintained Petitioner was unable to work as a CNA.

Dr. Bodner's causal connection opinion remained unchanged. Specifically, Dr. Bodner stated: "I have *** consistently in this record stated that my opinion was that she had an underlying chondromalacia and developing arthritis in her knee that was exacerbated by the fall that she described." Dr. Bodner explained the basis for his opinion was "the patient presented no evidence to me that she had been having significant problems with her knee prior to the fall and *** after the fall her knee just never responded." Dr. Bodner continued to recommend viscosupplementation or a partial knee replacement, opining the proposed treatments would be causally connected to the work injury.

On cross-examination, Dr. Bodner testified that he relied on Petitioner's history of having landed directly on her right knee, *i.e.*, striking the front of the knee on icy ground. Petitioner did not provide any outside clinical records. Dr. Bodner did not compare Petitioner's original MRI of the right knee with the repeat MRI. Dr. Bodner agreed the findings on the repeat MRI could be due to a degenerative process, and not an acute accident. Dr. Bodner also agreed that swimming could aggravate a degenerative arthritic condition. Dr. Bodner did not remember prescribing a cane for Petitioner and did not see a prescription or recommendation for a cane in his notes.

Respondent's section 12 examiner, Dr. Timothy Payne, an orthopedic surgeon, testified by evidence deposition on July 22, 2015, that he examined Petitioner on April 17, 2014. Dr. Payne summarized Petitioner's history as follows: "[The patient] stated that she sustained injuries to multiple body parts which included her neck, upper spine, thoracic spine, lumbar spine, the right shoulder and right knee on January 14, 2014. She was taking garbage bags out to a dumpster. Sidewalk had a patch of ice. She slipped on ice and fell. *** She twisted her right knee and landed on her right side contusing the right shoulder, the lower back and right hip." When asked about the reported mechanism of injury, Dr. Payne stated: "She basically said she slipped and fell and she twisted her right knee and landed on her right side. So the mechanism from what I gathered, she slipped. Her feet went out from underneath her. She twisted her right knee, and landed on her right side." Petitioner also related a prior injury to the right knee approximately a year earlier, but stated she had no residual problems with the knee after completing treatment.

Regarding her current injuries, Petitioner reported no progress with physical therapy. She reported being on Flexeril, Vicodin and ibuprofen. Dr. Payne noted the following complaints:

> "[W]hen I saw her on the 17th of April, she complained of bilateral arm weakness. She complained of numbness with writing activities using her right hand. She states if she sat for too long a time, her legs would go numb.
>
> Her walking was limited. She could only walk three blocks at a time. She gets occasional pain in the right knee. She's got occasional swelling into the ankle. Coughing and sneezing did not increase the pain in the lower back. She had

> no history of bladder or bowel problems; however, she stated she started having some bed wetting difficulties recently.
>
> She had difficulty going up and down stairs. She stated sitting caused her knee to feel stiff. Right shoulder pain limited her from doing overhead lifting activities. She complained of pain in the back that radiated to the right buttock."

In the pain and disability questionnaires Petitioner completed for Dr. Payne, she reported moderate to very severe problems with the right knee, severe problems with the spine, and severe overall disability. Dr. Payne noted that Petitioner reported using a cane or crutch to help ambulate.

On physical examination, Dr. Payne noted Petitioner was overweight. Petitioner walked with a normal reciprocal gait, without limping. During examination of the cervical spine, Petitioner complained of stiffness at the extremes of range of motion. The range of motion was full. In all, the cervical spine examination was benign. Examination of the right shoulder revealed mild evidence of impingement and tendinitis, and some stiffness with mildly decreased range of motion. Examination of the upper extremities was normal. On examination of the thoracic spine, Petitioner complained of pain to palpation in the midline. However, when she pushed her hands against resistance, there was no winging of the scapula to suggest muscle dysfunction. On examination of the lumbar spine, Petitioner complained of pain to palpation in the left and right paralumbar areas, greater on the right. The range of motion was mildly limited. Straight leg raise test was negative. Examination of the lower extremities showed no neurological problem. On examination of the right knee, Petitioner complained of some medial joint line tenderness. The range of motion was mildly limited. The knee was otherwise unremarkable. Dr. Payne felt the physical examination findings did not support Petitioner's subjective complaints.

Turning to the MRI studies performed March 13, 2014, Dr. Payne read the cervical MRI as showing a diffuse bulge at C6-C7 with some flattening of the thecal sac, but no herniation or spinal stenosis. Dr. Payne read the lumbar MRI as showing disc desiccation and degeneration at L4-L5 and L5-S1. Dr. Payne read the MRI of the right knee as showing a Baker's cyst, indicative of inflammation inside the knee joint, and some patellofemoral arthrosis/arthritis. There was also an indication of some inflammation of the medial collateral ligament.

Dr. Payne further testified that he viewed surveillance videos from March 5 to March 18, 2014. The videos showed Petitioner engaging in everyday activities. Petitioner was driving, getting in and out of a car without difficulty, and walking without difficulty. The videos further showed Petitioner picking up and carrying some lightweight boxes, somewhat awkwardly but without difficulty. Petitioner was also bending over, tending to objects in the car, and moving about without any signs of difficulty. She did not use a cane.

Dr. Payne further testified that he reviewed Petitioner's post-accident medical records, noting the medical records through February 4, 2014, showed some mild limitation in function, which improved over time, and physical therapy records showed atypical pain behaviors.

Dr. Payne diagnosed soft tissue strains of the right knee, low back, neck and right shoulder. He also diagnosed preexisting chondromalacia and early arthritis in the right knee and some degenerative changes in the cervical and lumbar spine. Dr. Payne opined Petitioner was at maximum medical improvement at the time of his examination and did not require further diagnostic studies or treatment for the work-related injuries. Regarding Petitioner's work status, Dr. Payne opined Petitioner could return to some, but not all, CNA duties. She could not lift, support or transfer patients. However, in his report introduced into evidence during the deposition, Dr. Payne had stated: "She is capable of returning to work without restriction, based on diagnostic studies and surveillance tapes reviewed."

During the arbitration hearing, Petitioner denied that any of her treating physicians released her to return to work full duty. Further, Petitioner denied that Respondent offered her light duty employment. On cross-examination, when asked whether Respondent had asked her to return to work on May 5, 2014, Petitioner responded: "I don't know." Petitioner was then asked whether Respondent had sent her a letter offering a return to work. Petitioner responded: "I got nothing." Respondent's counsel then showed Petitioner a copy of the letter and a certified mail receipt. Petitioner stated: "I've never seen that. That is not my handwriting. That is not my signature." Petitioner acknowledged the letter, offering her full duty work as a CNA, purported to be from Respondent and was addressed to her. The certified mail receipt was correctly addressed to her, although was not signed by her. Petitioner acknowledged that someone else at her residence could have signed the mail receipt.

Petitioner denied working for her private client after the accident. Petitioner admitted going to the client's house, stating she went with her daughters, who were also CNAs. Petitioner stated her daughters took over the care of the client. Petitioner denied receiving any compensation when she visited the client, stating the client paid her daughters. However, Petitioner then stated the client continued to pay her after she was unable to provide services. Upon further questioning, Petitioner stated her daughter got paid, and she did not get paid, when both of them were at the client's house. On cross-examination, Petitioner did not recall whether she visited the client's residence on March 5, March 11 or March 18, 2014. When asked whether she provided home healthcare services on those dates, Petitioner responded: "I don't remember the dates. I have not taken care of [the client] since the accident on January 14th because my body has not allowed me to." Petitioner stated when she visited the client after the accident, it was as a friend and not a provider of services. Lastly, Petitioner testified that Respondent paid temporary total disability benefits until sometime in April of 2014.

Respondent introduced into evidence surveillance videos, authenticated by private investigators on the case. The videos showed Petitioner walking with a mild limp. There were intervals when she moved normally. Further, Respondent offered into evidence the testimony of

Brook Coughran, a background investigator, who investigated why Petitioner frequently went to a certain residence depicted in the surveillance videos. Ms. Coughran testified that she looked up the published landline phone number and called the residence on April 8, 2014. The person answering the phone identified herself as Schyler Clark. Ms. Coughran posed as a neighbor down the street who was interested in home healthcare services. The person answering the phone told Ms. Coughran that she and her mother, who was the owner of the business, were CNAs who provided services to private clients. The person further stated that she took care of the resident of the house, and the business had no other clients at the time.

Schyler Clark (Schyler), Petitioner's daughter, testified as an adverse witness that she was a licensed CNA. Schyler admitted working with Petitioner at the residence of the private client, but stated she did not remember any dates or time periods when they did so. Schyler initially stated she did not remember answering the phone at the client's residence and having a conversation about CNA services on or about April 8, 2014. Upon further questioning, Schyler agreed that she did have a phone conversation and told the caller she provided home healthcare services. Schyler did not remember telling the caller she provided the services along with Petitioner.

The Arbitrator found Petitioner's "testimony and actions suspect." Nevertheless, the Arbitrator rejected the opinions of Dr. Payne and proceeded to find the work accident aggravated Petitioner's preexisting right knee condition, and the condition had not reached maximum medical improvement. The Arbitrator awarded: temporary total disability benefits from March 19, 2014, through the conclusion of the arbitration hearing on December 4, 2015; medical expenses in the sum of $773.47 pursuant to sections 8(a) and 8.2 of the Act; and prospective medical care prescribed by Dr. Bodner.

The Commission disagrees with the Arbitrator's rejection of the opinions of Dr. Payne. The Commission notes the inconsistent histories Petitioner provided, evidence of symptom magnification, the surveillance indicating Petitioner's physical abilities were much greater than she reported, and her evasive and inconsistent testimony. The Commission further notes that Petitioner worked for Respondent on light duty for a period of time in February of 2014. The Commission adopts the opinions of Dr. Payne that the accident caused sprain/strain type injuries, which reached maximum medical improvement by the time of the examination on April 17, 2014. Correspondingly, the Commission reduces the award of medical expenses to those Petitioner incurred through April 17, 2014, and vacates the award of prospective medical care. Turning to temporary disability benefits, in the request for hearing form Petitioner sought temporary total disability benefits beginning April 25, 2014. The parties stipulated Respondent had paid $2,860.00 in temporary total disability benefits. The Commission finds that no further temporary disability benefits are owed.

Having modified the Arbitrator's decision and award, the Commission remands the matter to the Arbitrator for further proceedings consistent with this decision.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 8, 2016, is hereby modified as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay related medical bills in evidence that Petitioner incurred through April 17, 2014, pursuant to §§8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that the awards of temporary total disability benefits and prospective medical care are 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 $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 18 2017
o-12/15/2016
SM/sk
44

Stephen Mathis

Mario Basurto

David L. Gore

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

CLARK, AMY
Employee/Petitioner

Case# **14WC010723**

17IWCC0013

RESTHAVE RETIREMENT & NURSING
Employer/Respondent

On 2/8/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

4768 MERTES & MERTES PC
BRIAN BRIM
4015 E LINCOLNWAY
STERLING, IL 61081

2965 KEEFE CAMPBELL BIERY & ASSOC
LINDSAY R VANDERFORD
118 N CLINTON ST SUITE 300
CHICAGO, IL 60661

STATE OF ILLINOIS)SS.

COUNTY OF Rock Island)

17IWCC0013

☐ 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)

AMY CLARK
Employee/Petitioner

v.

RESTHAVE RETIREMENT & NURSING
Employer/Respondent

Case # 14 WC 10723

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 **Gregory Dollison**, Arbitrator of the Commission, in the city of **Peoria, Illinois**, on **August 25, 2015, September 22, 2015, and December 4, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **January 14, 2014**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$16,144.16**; the average weekly wage was **$310.47**.

On the date of accident, Petitioner was **38** 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 **$2,860.00** for TTD, **$0** for TPD, **$0** for maintenance, and **$1,000.00** for other benefits, for a total credit of **$3,860.00**.

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 $220.00/week for 89-3/7 weeks, commencing March 19, 2014 through December 4, 2015, as provided in section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services of $773.47, as provided in Section 8(a) of the Act. Said payment shall be made consistent with the medical fee schedule

Respondent shall authorize the medical treatment as prescribed by Dr. Bodner, as provided in Section 8(a) of the Act.

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

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

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

Signature of Arbitrator

2/5/16
Date

ICArbDec19(b)

FEB 8 - 2016

STATEMENT OF FACTS:

Petitioner testified that she was a licensed CNA working for Resthave Retirement & Nursing on January 14, 2014. She testified that she was on duty that day and as part of her duties she was to take out the trash towards the end of her shift. Petitioner provided that the trash dumpsters were outside and that the sidewalk leading to the dumpsters was icy. Petitioner testified that as she traversed the icy sidewalk, she fell on her right side. Specifically, she provided that she fell on the front right side of her right knee. She testified that this was the first impact of the fall. Petitioner stated that she was not able to get up by herself. She noted there were workers doing some construction on the site and one of them came over and helped her up. Immediately thereafter, she reported the incident to the "nurses" who are considered her supervisor. Petitioner stated that an accident report was completed and she was told to see a doctor.

On the date of accident, Petitioner presented to Morrison Community Hospital where she saw Dr. Duncan Dinkha. Records submitted show she presented with a history of "...taking the trash out and she slipped on the ice and she fell on her back." Also recorded was that "[s]he is complaining of back pain in the mid lower part of the back and right knee pain." An examination of the right knee showed slight tenderness on palpation of the lateral side of the right knee with slight limitation of movement of the knee, mainly flexion. Also noted was slight limitation of bearing weight to the right knee due to pain. There was no swelling or discoloration of the right knee. X-rays taken were read to show no evidence of acute traumatic injury. Dr. Dinkha diagnosed right knee sprain and muscular strain of the lower and mid back. Medication was prescribed and Petitioner was taken off work through January 21, 2014. (PX group 1, pp4-5,7)

On January 21, 2014, Petitioner was seen by Brian Glasz, PA-c, at the Morrison Family Clinic. Her off work restriction was continued. When she returned to the Morrison Family Clinic on January 28, 2014, Physcians Assistant Glasz recorded a history that Petitioner returned secondary to injury on January 14th when she slipped on ice while carrying 2 bags of trash landing on her knee, buttocks and right-sided back. Petitioner's right knee was injected with cortisone and she was to remain off work. On February 4, 2014, Petitioner reported right knee improvement. She was released to light-duty work and physical therapy was ordered. (PX group 1, pp4-14)

Petitioner's initial physical therapy evaluation occurred on February 10, 2014. At that time a history was recorded that Petitioner slipped and fell down on ice as she was carrying garbage out. It was recorded that she twisted her right knee and fell down on the right side. (PX group 1, p.62) Petitioner attended therapy sessions through March 28, 2014. (PX group 1, p.92)

On February 14, 2014, Petitioner saw her primary care physician, Dr. Kelley Guthrie, at Whiteside County Community Health Clinic with a history of slipping on ice at work. In addition to right knee complaints, Petitioner also complained of low back, cervical and shoulder discomfort. A MRI of the right knee was ordered and Petitioner was taken off work. (PX group 1, pp.27-28) The MRI when completed on March 13, 2014 demonstrated 1.) chronic appearing meniscal capsular separation with adjacent locualted fluid; 2.) osteoarthritis changelar separation with adjacent locualted fluid; 2.) osteoarthritis changes of the patellofemoral joint; and 3.) small joint effusion. (PX group 1, p.36) On March 20, 2014, Dr. Guthrie authored a note taking Petitioner off work. (PX group 1, p.47)

At Respondent's request, Petitioner underwent a Section 12 examination with Dr. Timothy Payne on April 17, 2014. In his report dated April 24, 2014, Dr. Payne recorded that Petitioner provided a history that she injured her neck, thoracic spine, lumbar spine, right shoulder and right knee on January 12, 2014 when she

slipped and fell on a patch of ice on the sidewalk. The doctor provided that Petitioner reported that she twisted her right knee and landed on her right side. Dr. Payne noted that he performed an examination, reviewed medical documentation and observed surveillance video. Dr. Payne opined that Petitioner sustained a contusion to her low back, right knee and right shoulder as a result of the January 14, 2014 fall at work. He also felt that Petitioner did not sustain a significant injury to her neck. (RX1, dep.#2) Dr. Payne opined that the MRI of the knee suggested there was some underlying chondromalacia, but nothing significant. Dr. Payne opined that Petitioner was essentially at maximum medical improvement. He provided that based on his examination and review of information including surveillance video, Petitioner could return to work without restrictions. He further opined that she required no further treatment as her contusions had resolved. (RX1, dep.#2)

Petitioner returned to Dr. Guthrie on May 2, 2014. Petitioner reported that her right knee gives out and collapse with minimal use. The doctor continued Petitioner's medication regiment and indicated she could return to work in a sitting position. (PX group 1, pp. 49-54)

On May 5, 2014, Ms. Kristi Christiansen, Respondent's Nursing Administrator, authored a letter advising Petitioner that inasmuch as she had been released to return to regular unrestricted work she would be placed on the work schedule effective May 9, 2014. (RX7)

On May 30, 2014, Dr. Guthrie referred Petitioner for an orthopedic evaluation regarding her right knee. (PX group 1, pp.56, 58)

On July 30, 2014, Petitioner saw Dr. Russell J. Bodner of the Midwest Orthopaedic Institute. Petitioner presented and described an injury in January 2014 when she fell, while carrying two garbage bags, striking the front of her knee on the icy ground and then falling onto her right side. Dr. Bodner performed an examination and reviewed a MRI scan which he felt demonstrated advanced patellofemoral chondromalacia and early arthritic change. Also noted was arthritic change in the medial compartment and some laterally which was described as small. Dr. Bodner's impression was that "…she had a direct blow on the front of her knee when she fell, exacerbating the underlying patellar chondromalacia and early arthritis." The doctor added, "…this injury seriously exacerbated the underlying significant chondromalacia and it has in fact put her over the edge from recovering." Dr. Bodner diagnosed right knee patellar pain and arthritis. He administered a cortisone injection and returned her to sedentary work only. (PX group 1, pp.115-116, 119)

On September 24, 2014, Petitioner reported that the cortisone injection provided temporary relief. She complained of pain in the anterior knee with radiation down the leg. She had popping, swelling and occasionally the knee would give out. Dr. Bodner offered treatment options to include viscosupplementation or partial knee replacement. Work restrictions were continued. (PX group 1, pp.125,126)

Petitioner returned to Dr. Bodner on October 27, 2014, February 16, 2015, and April 13, 2015. Her complaints continued and the doctor's recommendation remained constant. On May 18, 2015, the doctor ordered a repeat right knee MRI which was completed on May 20, 2015. On June 3, 2015, Dr. Bodner provided that the MRI showed advanced degenerative changes in the patellofemoral joint. There was medial compartment degeneration and degeneration in the anterior cruciate ligament. Also noted was significant medial collateral ligament bursitis with fluid. Dr. Bodner wrote, "Overall, my position is unchanged. She has had exacerbation of a preexisting arthritic condition in her knee." (PX group 1, pp.128,135,137-138, 143,146)

Respondent's Section 12 examiner, Dr. Timothy Payne, testified via deposition in this matter on July 22, 2015. Dr. Payne testified that he saw Petitioner on April 17, 2014. At that time she provided a history of taking garbage bags out to a dumpster when slipped on ice and fell. The doctor indicated Petitioner provided that she twisted her right knee and landed on her right side. Petitioner also provided a history that she hurt her right knee

approximately one year prior, was treated, and had no problems with her knee following said treatment. (RX1, pp. 7-9)

Dr. Payne testified that he performed an examination and reviewed medical documentation. Dr. Payne provided that the right knee MRI showed a Baker's cyst which he indicated was indicative of inflammation inside the knee joint. He also noted she had some patellofemoral arthrosis/arthritis and an indication of some inflammation of the medial collateral ligament. The doctor also testified that he reviewed video surveillance, which indicated showed Petitioner driving, getting out of a car without difficulty, walking and opening and closing a door. The doctor provided that the surveillance didn't show any strenuous activity indicating "it showed everyday activity." (RX1, pp. 19-20)

Dr. Payne testified the he diagnosed Petitioner with soft tissue strains to the right knee, the lower back and shoulder. He opined she also had preexisting arthritic conditions regarding the right knee. When asked if Petitioner's modalities were related to the work injury, Dr. Payne opined that the arthritis preexisted the work injury. He felt the work injury was predominantly a slip and fall with subsequent contusions. The doctor provided that the slip and fall did not cause the arthritis, but that the underlying arthritis could slow down recovery. He felt she was at maximum medical improvement on April 17, 2014 and didn't need any further diagnostic studies. The doctor stated his opinion was based on Petitioner's clinical exam and the records he reviewed. He also noted the surveillance video suggested Petitioner could do activities fairly comfortably at a low activity level. (RX1, pp.25-26, 28) He felt Petitioner was capable of returning to work at the time of his examination. (RX1, p.30)

On cross-examination, Dr. Payne testified that he felt Petitioner was capable of performing some of the functions of her job, but not all. He felt she was capable of performing in a light duty capacity. (RX1, pp.37-38) Dr. Payne testified that he would support the idea of Petitioner being a candidate for viscosupplementation treatment. He felt it would be a good step before going down a surgical path. When asked if Petitioner's arthritic condition could have been exacerbated by a direct fall on the knee, the doctor stated, "Again, depending on the mechanism of injury you can have it cause either by a direct blow or by twisting-type based on what part of the knee is arthritic, so if you're talking about patellofemoral pain, kneecap pain, land on the knee directly would be a cause to aggravate underlying arthritis. If you have medial or lateral inside or outside joint pain and you have a twist injury, that would aggravate that compartment of arthritis." (RX1, p.42) Dr. Payne stated that a direct blow to the knee could exacerbate the underlying symptoms of chondromalacia and patellofemoral pain. He added that "also it could not necessarily be related to that but the response to treatment." (RX1, p.43) The doctor reiterated his opinion that Petitioner had underlying conditions that was aggravated by the fall. He felt that a surgical solution presented a lot more risk than benefit. He felt viscosupplementation treatment was a preferred option. (RX1, pp.46-47)

Petitioner's treating physician, Dr. Russell Bodner, also testified via deposition in this matter. Dr. Bodner testified that when he initially saw Petitioner on July 30, 2014, she presented with a history that she was carrying two garbage bags when she slipped on ivy ground striking the front of her knee on the right side and then fell over on her right side. (PX2, pp.7-8) Dr. Bodner testified that he performed an examination and reviewed Petitioner's prior medical history. He reviewed a MRI which he indicated demonstrated significant disease under her kneecap with early arthritic change in the knee. He stated that said condition could be asymptomatic. (PX2, p.9)

Dr. Bodner testified that he has consistently held the position that Petitioner had an underlying chondromalcia and developing arthritis in her knee that was exacerbated by the fall she had at work. The doctor explained that Petitioner "...presented no evidence to me that she had been having significant problems with her knee prior to the fall and that after the fall her knee just never responded." He opined that Petitioner was not able to work as a CNA and that she was not at maximum medical improvement. (PX2, pp.20-21) Dr. Bodner

provided that it was possible to treat her with viscosupplementation injections which he indicated "...would give maybe a 50/50 chance of giving her some temporary relief..." He however opined that replacement of the patellofemoral joint had the highest chance of providing substantial relief. (PX2, p.22)

With respect to Dr. Bodner's opinions regarding limited or no work, the doctor testified that on July 30, 2014, he placed Petitioner on sedentary work only, no lifting greater than 10 pounds. On September 24, 2014, he provided a work note that indicated limited duty, but also indicated "may not return to work..." The doctor explained that "...the difference between the sedentary work note that was prior to this to not work is typically done by me...the patient will tell me that the employer does not have sedentary work for them. So the choice is full work or no work, in which I choose no work." The doctor provided that he would have continued his previous restriction on October 27, 2014 and February 16, 2015. By April 13, 2015, he placed her on limited use and may not return to work. (PX2, pp.10-18, 39)

Petitioner testified that none of her treating physicians informed her that she could return to work without restrictions. She indicated that some of the doctors returned her to light duty work. Petitioner stated she was never offered a return to light duty employment with Respondent. She does not know if she is still classified as an employee of Respondent.

Petitioner testified she was employed by a private client on January 14, 2014. Petitioner testified her employment for this individual was as a CNA. She indicated that after January 14, 2014, she never worked for her again. Petitioner testified she continued to go to the home of this individual with her daughters, whom she testified took over her employment responsibilities as of the date of her work incident. Petitioner testified her daughters continued working for that client up until December 27, 2014, and they received compensation for their work. Petitioner testified this compensation was paid on a weekly basis. Petitioner testified she did not file a tax return in 2014, and her daughter claimed her as a dependent that year. Petitioner testified she received TTD from her date of loss through April of 2014.

Petitioner testified her daughter, Schyler, was licensed as a CNA as well and had once owned a white Ford Focus. Petitioner testified that prior to the accident she and her daughter ran a home healthcare business. She indicated that prior to the work incident she did do such work with her daughter, helping a couple of clients in their homes. Petitioner testified she was working for Sylvia Bush at one point. She indicated that she had not taken care of Ms. Bush since the date of accident and that she could not recall her whereabouts on March 5, 2014. Petitioner testified that Ms. Bush paid her weekly and checks were made out in her name up until her work incident and then to her daughter after her January 14, 2014 date of accident. On re-direct examination, Petitioner testified that checks were made out in her name up until April of 2014.Petitioner indicated that Ms. Bush has since passed away. Petitioner provided that other than Ms. Bush, she has had no other clients.

Mr. Denis Burkott, Respondent's first witness, testified he was employed by Photofax as a personal investigator and provided surveillance services with regard to Petitioner's claim. Mr. Burkott testified that it was normal practice at Photofax to work with an associate in rural settings such as the one in this claim. He testified he was present for all five days of surveillance conducted and was accompanied by an associate each day. Mr. Steve Bjelanovic, Mr. Nick Galvin, and Mr. Kyle Landes testified as to their roles as Mr. Burkott's associates on their assigned days of surveillance and the accuracy of the documentation with regard to the surveillance they shot and their parts of the overall report which they created in conjunction with Mr. Burkott. Mr. Burkott also verified he was present for all five days of surveillance conducted and that the report he and his associates completed with respect to Petitioner was true and accurate with respect to the goings on of each of those five dates – March 5, 11, 12, 13, and 18, 2014.

The Arbitrator has reviewed the surveillance provided and notes. (RX2, RX3) On March 5, 2014, it appears Petitioner attended a medical appointment and then drove to a gas station and a King's Kloset clothing

store where she carried a storage container with folded items on top. She appeared to be running errands before arriving at a private residence located at 510 6th Street in Erie, Illinois, where it appears she remained for over 7 hours. On March 11, 2015, it appears Petitioner went to the same residence, where it appears she remained for at least 2-1/2 hours. On March 12, 2015, a female driving a white Ford Focus went to the same residence. Petitioner was not observed. On March 13, 2015, it appears Petitioner went to a medical appointment, then home, and then an antique store. On March 18, 2014, it appears Petitioner went to Casey's General Store, attended a medical appointment, and visited two drug stores before she returned home. She then left minutes later for the aforementioned residence where it appears she remained for over 2-1/2 hours. Upon her arrival at the residence, it appears as Petitioner bent at the waist on a couple of occasions and handled some bags of goods. Throughout the surveillance, Petitioner is observed ambulating with a limp. Some days it was more pronounced than the others. At no point in the surveillance does Petitioner appear to be utilizing a cane.

Ms. Brook Coughran testified on behalf of Respondent on two separate occasions. During her initial testimony, Ms. Coughran testified that she was employed by Photofax as a background investigator. Ms. Coughran testified she began working on Petitioner's file in late March or early April of 2014 based upon a request by Brentwood Services. Ms. Coughran testified that prior surveillance performed by her company indicated Petitioner repeatedly went to a residential home for an unknown reason, and she was to investigate further. Ms. Coughran testified she had reviewed the surveillance report and recalled the address of 510 6th Street in Erie, Illinois. To pursue her investigation, Ms. Coughran testified she obtained that residence's published landline phone number from a web site, 411.com. Ms. Coughran testified to calling that number and expressing her interests in obtaining CNA services for her parents as they believed Sylvia Bush, who was living there, was receiving those same services. Ms. Coughran testified that once she had explained why she was calling, the person who answered identified herself as Schyler Clark.

Ms. Schyler Clark, Respondent's interim witness, testified to her relation to Petitioner as her daughter. Ms. Clark testified she did have her CNA license and had worked with her mother at the home of Sylvia Bush. Ms. Clark testified she did not recall any specific conversation wherein she identified herself as Schyler Clark and informed a caller she and her mother worked for themselves while she was at the Bush residence. Ms. Clark was unable to recall any phone conversation wherein she identified her mother as the manager of a business where they worked together. Ms. Clark testified she had a phone conversation with someone saying she provided CNA services but not that she provided those services with her mother.

Ms. Clark testified she would charge about $9.50 an hour for services such as showers, cooking, cleaning, transportation to doctor's appointments, grocery shopping, and helping run errands. Ms. Clark stated that she did not charge Ms. Bush any amount for her services. She indicated that it was her sister who was charging for services provided to Ms. Bush.

Ms. Coughran resumed the stand and testified in detail to the conversation she had with Ms. Schyler Clark wherein Ms. Clark indicated she worked at the Bush residence and that she and her mother worked together providing CNA services. Ms. Coughran testified Ms. Clark conveyed that her mother was the owner of the business and should be contacted regarding any pricing information, and that they were attempting to grow the business by gaining other clients. Ms. Coughran testified to the truth and accuracy of Respondent's Exhibit 3, her background check report which also details that conversation. She testified she found no further information with regard to this business.

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

Relying on *Sisbro vs Industrial Comm'n*, 207 Ill.2d 193, 278 Ill.Dec 70, 797 N.E.2d 655 (2003) , the Arbitrator finds that a causal relationship exists between Petitioner's right knee condition of ill-being and the accident sustained on January 14, 2014.

There is no dispute that Petitioner sustained an accident on January 14, 2014. On that day she fell on the front right side of her right knee. On the date of accident, Petitioner presented to Morrison Community Hospital with a history of "...taking the trash out and she slipped on the ice and she fell on her back." An examination of the right knee showed slight tenderness on palpation of the lateral side of the right knee with slight limitation of movement of the knee, mainly flexion. Also noted was slight limitation of bearing weight to the right knee due to pain. Petitioner was diagnosed with a right knee sprain. Thereafter, she treated at the Morrison Family Clinic where she received a cortisone injection and prescribed physical therapy. By February 14, 2014, Petitioner saw her primary care physician, Dr. Kelley Guthrie, at Whiteside County Community Health Clinic. A MRI of the right knee was ordered which when completed demonstrated 1.) chronic appearing meniscal capsular separation with adjacent locualted fluid; 2.) osteoarthritis changelar separation with adjacent locualted fluid; 2.) osteoarthritis changes of the patellofemoral joint; and 3.) small joint effusion. Dr. Guthrie ultimately referred Petitioner for an orthopedic evaluation regarding her right knee.

Before seeing an orthopedic physician, Petitioner was seen by Dr. Timothy Payne for a Section 12 examination. In his report dated April 24, 2014, Dr. Payne recorded that Petitioner reported that she twisted her right knee and landed on her right side. Dr. Payne noted that he performed an examination, reviewed medical documentation and observed surveillance video. Dr. Payne opined that Petitioner sustained a contusion to her low back, right knee and right shoulder as a result of the January 14, 2014 fall at work. Dr. Payne opined that the MRI of the knee suggested there was some underlying chondromalacia, but nothing significant. Dr. Payne opined that Petitioner was essentially at maximum medical improvement and that she required no further treatment as her contusions had resolved.

On July 30, 2014, Petitioner saw Dr. Russell J. Bodner of the Midwest Orthopaedic Institute. Petitioner presented and described an injury in January 2014 when she fell, while carrying two garbage bags, striking the front of her knee on the icy ground and then falling onto her right side. Dr. Bodner performed an examination and reviewed a MRI scan which he felt demonstrated advanced patellofemoral chondromalacia and early arthritic change. Also noted was arthritic change in the medial compartment and some laterally which was described as small. Dr. Bodner's impression was that "...she had a direct blow on the front of her knee when she fell, exacerbating the underlying patellar chondromalacia and early arthritis." The doctor added, "...this injury seriously exacerbated the underlying significant chondromalacia and it has in fact put her over the edge from recovering." Dr. Bodner diagnosed right knee patellar pain and arthritis. He administered a cortisone injection which provided temporary relief. As Petitioner continued to complain of symptoms, Dr. Bodner offered treatment options to include viscosupplementation or partial knee replacement.

Petitioner continued to treat with Dr. Bodner and his recommendation remained constant. On May 18, 2015, the doctor ordered a repeat right knee MRI which when completed on May 20, 2015 showed advanced degenerative changes in the patellofemoral joint. There was medial compartment degeneration and degeneration in the anterior cruciate ligament. Also noted was significant medial collateral ligament bursitis with fluid. Dr. Bodner wrote, "Overall, my position is unchanged. She has had exacerbation of a preexisting arthritic condition in her knee."

Both Dr. Payne and Dr. Bodner testified in this matter. Dr. Payne testified that she had preexisting arthritic conditions regarding the right knee. When asked if Petitioner's modalities were related to the work injury, Dr. Payne opined that the arthritis preexisted the work injury. He felt the work injury was predominantly a slip and fall with subsequent contusions. The doctor provided that the slip and fall did not cause the arthritis, but that the underlying arthritis could slow down recovery. He felt she was at maximum medical improvement

on April 17, 2014 and didn't need any further diagnostic studies. On cross-examination, Dr. Payne testified that he would support the idea of Petitioner being a candidate for viscosupplementation treatment. He felt it would be a good step before going down a surgical path. When asked if Petitioner's arthritic condition could have been exacerbated by a direct fall on the knee, the doctor stated, "Again, depending on the mechanism of injury you can have it cause either by a direct blow or by twisting-type based on what part of the knee is arthritic, so if you're talking about patellofemoral pain, kneecap pain, land on the knee directly would be a cause to aggravate underlying arthritis. If you have medial or lateral inside or outside joint pain and you have a twist injury that would aggravate that compartment of arthritis." Dr. Payne stated that a direct blow to the knee could exacerbate the underlying symptoms of chondromalacia and patellofemoral pain. The doctor reiterated his opinion that Petitioner had underlying conditions that was aggravated by the fall. He felt that a surgical solution presented a lot more risk than benefit. He felt viscosupplementation treatment was a preferred option.

Petitioner's treating physician, Dr. Bodner, testified that he has consistently held the position that Petitioner had an underlying chondromalcia and developing arthritis in her knee that was exacerbated by the fall she had at work. The doctor explained that Petitioner "...presented no evidence to me that she had been having significant problems with her knee prior to the fall and that after the fall her knee just never responded." He opined that Petitioner was not able to work as a CNA and that she was not at maximum medical improvement. Dr. Bodner also provided that it was possible to treat her with viscosupplementation injections which he indicated "...would give maybe a 50/50 chance of giving her some temporary relief..." He however opined that replacement of the patellofemoral joint had the highest chance of providing substantial relief.

As noted in *Sisbro*, it has long been recognized that, in preexisting condition cases, recovery will depend on the employee's ability to show that a work-related accidental injury aggravated or accelerated the preexisting disease such that the employee's current condition of ill-being can be said to have been causally connected to the work-related injury and not simply the result of a normal degenerative process of the preexisting condition. *Caterpillar Tractor Co. v. Industrial Comm'n*, 92 Ill.2d 30, 36-37, 65 Ill.Dec. 6, 440 N.E.2d 861 (1982); *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); *Fittro 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. *Baggett v. Industrial Comm'n*, 201 Ill.2d at 199, 266 Ill.Dec. 836, 775 N.E.2d 908. "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, 65 Ill.Dec. 6, 440 N.E.2d 861; *Williams v. Industrial Comm'n*, 85 Ill.2d 117, 122, 51 Ill.Dec. 685, 421 N.E.2d 193 (1981); *County of Cook v. Industrial Comm'n*, 69 Ill.2d 10, 18, 12 Ill.Dec. 716, 370 N.E.2d 520 (1977); Accidental injury need not be the sole causative factor, nor even the primary causative factor, as long as it was a causative factor in the resulting condition of ill-being. *Rock Road Construction Co. v. Industrial Comm'n*, 37 Ill.2d 123, 127, 227 N.E.2d 65 (1967).

In this case, Dr. Bodner testifies that to a reasonable degree of medical and orthopedic surgical certainty that Petitioner's work related injury was the precipitating event which caused previous knee issues to become debilitating. The Section 12 examiner, Dr. Rayne reaches the same conclusion opining "...that she has an underlying condition that was aggravated by the fall..."

In support of the Arbitrator's decision related to issue (L.), What temporary benefits (TTD) are in dispute, the Arbitrator finds as follows:

Petitioner testified and the records show that none of Petitioner's treating physicians indicated that she could return to work in a full duty capacity. On the date of accident, Petitioner saw Dr. Dinkha of Morrison Community Hospital. At that time, the doctor took her off work through January 21, 2014. She remained on an off work status until February 4, 2014 when she was released to light-duty. Thereafter, she remained on light-duty status until Dr. Guthrie took her off work on February 14, 2014. On May 2, 2014, Dr. Guthrie provided she could return to work in a sitting position.

On May 30, 2014, Dr. Guthrie referred Petitioner for an orthopedic evaluation regarding her right knee. Petitioner saw Dr. Bodner of the Midwest Orthopaedic Institute on July 30, 2014. At that time, Dr. Bodner diagnosed right knee patellar pain and arthritis, administered a cortisone injection and returned her to sedentary work only. Dr. Bodner sedentary restrictions continued through his deposition testimony. At that time, the doctor testified Petitioner was not at maximum medical improvement and "[s]he is not able to work certainly as a CNA."

Contrary to Dr. Bodner's assertion, Respondent's Section 12 examiner, Dr. Payne, indicated in his April 24, 2014 report that Petitioner was essentially at maximum medical improvement and could return to work without restrictions. In his deposition, the doctor seemed to hedge his opinion indicating Petitioner was capable of performing some of the functions of her job, but not all. He felt she was capable of performing in a light duty capacity. He provided that the video surveillance suggested Petitioner could do activities fairly comfortably at a low activity level and Petitioner was capable of returning to work at the time of his examination.

Petitioner testified that Respondent did not offer her any light-duty work. On May 5, 2014, Respondent authored a letter advising Petitioner that inasmuch as she had been released to return to regular unrestricted work she would be placed on the work schedule effective May 9, 2014. Petitioner testified "I don't know" when asked if she received the May 5, 2014 offer from Respondent to return to work. When presented with the letter at trial, Petitioner stated, "I got nothing. I have never seen the document." She indicated that prior to trial she had no knowledge of a return to work offer. The letter which was marked as Respondent's exhibit 7, bears the letterhead of Resthave and is addressed to Petitioner. It is accompanied by a certified mail receipt which Petitioner testified she had not signed. A review of the receipt does not bear a signature. Petitioner testified to verify the address listed on the certification was her correct home address.

Video surveillance was submitted at trial. It appears Petitioner was surveyed on five dates – March 5, 11, 12, 13, and 18, 2014. As noted above, the Arbitrator has reviewed the surveillance. On three different dates, Petitioner is observed arriving and remaining at a private residence located at 510 6th Street in Erie, Illinois. Specifically, on March 5, 2014, amongst other activities, Petitioner arrived at the residence where she appears to remain for over 7 hours. On March 11, 2015, it appears Petitioner went to the same residence, where it appears she remained for at least 2-1/2 hours. On March 18, 2014, it appears Petitioner arrived and remained at the residence for over 2-1/2 hours. Upon her arrival at the residence, it appears as Petitioner bent at the waist on a couple of occasions and handled some bags of goods. Throughout the surveillance, Petitioner is observed ambulating with a limp. Some days it was more pronounced than the others. At no point in the surveillance does Petitioner appear to be utilizing a cane.

Throughout these proceedings, Petitioner's testimony seemed evasive and suspect. Evidence submitted show that with exception of the period between February 4, 2014 through February 14, 2014 (apparently she was working light-duty for Respondent. See RX8 and PX1, p.62), Petitioner received TTD benefits through April 24, 2014. During that period it appears Petitioner was providing services to Ms. Bush on at least three occasions for a minimum of 2-1/2 hours, the last being March 18, 2014. Petitioner's testimony that she did not receive any payments for said services after the date of accident is suspect. Initially, she testified that checks

from Ms. Bush were made out in her name and then to her daughter after the date of accident. She later testified that the checks were made out in her name until April 2014.

While the Arbitrator finds Petitioner's testimony and actions suspect, the Arbitrator is not persuaded by Dr. Payne's April 24, 2014 opinion that Petitioner was essentially at maximum medical improvement and could return to work without restrictions. As noted above, in his deposition Dr. Payne doctor seemed to hedge his opinion indicating Petitioner was capable of performing some of the functions of her job, but not all. The "but not all" reference is supported by his own testimony that the surveillance video suggested Petitioner could do activities fairly comfortably at a low activity level. He felt she was capable of performing in a light duty capacity.

With the exception of Dr. Payne who hedged his opinion, none of the medical providers opined Petitioner could to return to work full duty as a CNA. Having said that, it appears Petitioner performed and received payment for services to Ms. Bush at least through March 18, 2014. As a result, the Arbitrator finds Petitioner TTD benefits should commence March 19, 2014 through December 4, 2015, the date of arbitration. Respondent is entitled to a credit for all TTD benefits paid.

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

Respondent denial of benefits is based on its position that Petitioner's condition of ill-being is not related to the accident sustained. Having reconciled in favor of Petitioner, the Arbitrator finds Respondent shall pay reasonable and necessary medical services of $773.47, as provided in Section 8(a) of the Act.

The Arbitrator further finds that Respondent shall authorize the treatment regimen as prescribed by Dr. Bodner. Both Dr. Bodner and Dr. Payne agree that further treatment is indicated. Dr. Bodner opines that viscosupplementation therapy is an appropriate therapy for Petitioner based on her current condition from her work injury. Dr. Bodner testifies that viscosupplementation has a 50-50 chance of success. He further testifies that a partial knee replacement has the highest chance of substantial pain relief. Dr. Payne testified that he would counsel against partial knee replacement for Petitioner until viscosupplementation is attempted.

In support of the Arbitrator's decision related to (O.) Determination of Workers' Compensation Fraud, the Arbitrator finds as follows:

Based on the Arbitrator's finding above, a determination of whether Workers' Compensation Fraud was perpetrated is rendered moot.

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Wiley Moore,

Petitioner,

vs.

NO: 13 WC 39970

17IWCC0014

Gleeson Asphalt Inc.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of medical expenses, 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. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 29, 2015, is hereby affirmed and adopted.

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

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

17IWCC0014

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 19 2017
TJT:yl
o 11/29/16
51

Michael J. Brennan

Kevin W. Lamborn

DISSENT

Since I disagree with the Arbitrator's determination that Petitioner was lacking in credibility as well as her reliance on the suspect opinion of record reviewer Dr. Lehman, I must respectively dissent. More to the point, I found the so-called "inconsistencies" cited by the Arbitrator, in the form of omitted records and allegedly incomplete histories, to be insignificant and by no means dispositive on the question of causation.

Furthermore, I find it difficult to rationalize the Arbitrator's attempts to discredit the opinions of both Dr. Purvines, Petitioner's treating orthopedic surgeon, and Dr. Backer, Respondent's initial §12 examining physician, in favor of the opinion of Dr. Lehman, a physician who never examined the Petitioner and who was hired after Dr. Backer's opinion proved less than favorable to the defense. Indeed, such circumstances smack of "doctor shopping", and at the very least should not form the basis for the denial of compensation, particularly in light of the questions raised by Dr. Lehman's "settlement agreement" with the Missouri State Board of Registration for the Healing Arts over claims of professional misconduct associated with an unrelated independent medical examination.

As a result, I would reverse the Arbitrator and find that Petitioner proved by the preponderance of the credible evidence that his current condition of ill-being with respect to his neck, right shoulder, and right arm is causally related to his November 20, 2013 accident, and would award compensation accordingly.

Thomas J. Tyrrell

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

MOORE, WILEY
Employee/Petitioner

Case# **13WC039970**

GLEESON ASPHALT INC
Employer/Respondent

17IWCC0014

On 9/29/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.10% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4488 THE PERICA LAW FIRM PC
BOB L PERICA
229 E FERGUSON AVE
WOOD RIVER, IL 62095

5074 QUINTAROS PRIETO WOOD & BOYER
MICHAEL J SCULLY
233 S WACKER DR 70TH FL
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF MADISON)

17IWCC0014

☐ 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)

Wiley Moore
Employee/Petitioner

v.

Gleeson Asphalt, Inc.
Employer/Respondent

Case # **13** WC **39970**

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 **Lindsay**, Arbitrator of the Commission, in the city of **Collinsville**, on **July 30, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

B. ☐ Was there an employee-employer relationship?

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

D. ☐ What was the date of the accident?

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

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

G. ☐ What were Petitioner's earnings?

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

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

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

K. ☒ 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 **Are PX 6, PX 6A, and RX 6 admissible?**

17IWCC0014

FINDINGS

On the date of accident, **November 20, 2013**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$30.38 per hour**; the average weekly wage was **$1,215.20**.

On the date of accident, Petitioner was **46** years of age, ***single*** with **1** dependent child.

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

Respondent shall be given a credit of **$54,619.92** for TTD, **$n/a** for TPD, **$n/a** for maintenance, and **$n/a** for other benefits, for a total credit of **$54,619.92**.

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

ORDER

Petitioner failed to prove that his current condition of ill-being is causally connected to his injury. Petitioner's claim for prospective medical care, medical bills, temporary total disability benefits, and penalties and attorney's fees is denied. No benefits are awarded.

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

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

Signature of Arbitrator

September 27, 2015
Date

ICArbDec19(b)

SEP 29 2015

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Arbitrator finds:

According to the medical records Petitioner underwent an MRI of the cervical spine on December 3, 2009 which showed an osteophyte complex on the right at C5-6 with neuroforaminal encroachment and probable exiting nerve root impingement. Uncoverteberal degenerative changes were noted, as well as, disc osteophyte complex on the right encroaching on the right neuroforamen and contacting the right exiting nerve root. There was mild disc bulging at C4-5 level impinging on the thecal sac. Mild ventral effacement of the thecal sac and flattening of the cervical cord was also observed at this level. (RX 4).

Petitioner underwent a second cervical MRI on November 1, 2011 of the cervical spine. The impression was increasing degenerative disc disease and increased disc osteophyte complex at C4-5 and degenerative changes at C5-6 and the remainder of the cervical spine (RX 4). C4-5 had a large central disc osteophyte complex that had increased in size. There was mild flattening along the ventral midline cord and mild bilateral foraminal narrowing (RX 4). Also at C5-6 there was a broad-based disc and endplate spurs with effacement of the ventral CSF with moderate right greater than left foraminal narrowing (RX 4; RX 2, p. 9/15)

Approximately two years later,on November 21, 2013 Petitioner was examined by Dr. Carr for complaints of constant aching, burning, and discomfort in the right trapezial muscle and a constant burning and shooting discomfort on the side of his right shoulder. He also complained of frequent numbness, burning and tingling in the back of his hand. Petitioner described a work injury on November 20, 2013 when he was working, walking backwards, and stepped in an uncovered waste water drainage hole. One leg fell into the hole while the other one remained above ground. Petitioner struck his flank and right knee along with his right elbow and jammed his shoulder superiorly and his neck into lateral flexion and extension. Petitioner reported to the doctor that he would be filing a report with his employer but his superintendent and foreman were immediately notified of the injury. Dr. Carr conducted a physical examination concluding that it was more probable than not that Petitioner was injured as a result of the traumatic forces experienced during the accident. Petitioner underwent palliative care including manipulations wit heat, interferential stimulation, myofascial releases, and stretching. Petitioner was told to avoid heavy lifting and use ice. (RX 2, pp. 2-3)

On November 22, 2013 Petitioner presented to Dr. Kai-Chun Yang and gave the same history of injury. His complaints included injury to his right side, neck, arm, shoulder, elbow, and left back. A history of degenerative disc disease was noted. The plan was to obtain images of the right elbow, shoulder and lumbar spine. "(RX 2, p. 3)

On November 25, 2013 Petitioner signed his Application for Adjustment of Claim herein alleging that he injured his right shoulder, right elbow, and right knee on November 20, 2013 while putting plastic down and he fell in an uncovered storm drain. (PX 2)

Petitioner continued to treat with Dr. Carr on November 23, 2013, November 25, 2013, and November 27, 2013 through December 13, 2013 during which time he received manipulations, stimulation, heat and stretching. (RX 2, p. 3) On November 25, 2013 Dr. Yang had Petitioner undergo cervical spine x-rays due to a fall. The history sheet reflected Petitioner having fallen into a man hole five days earlier with right shoulder and elbow pain and mild cervical and lumbar pain. They revealed early osteoarthritic changes. He also ordered right shoulder and elbow x-rays due to pain and trauma which also showed osteoarthritic changes of the right shoulder and elbow with no acute process. Mild lumbar spine x-rays also showed mild osteoarthritic changes but no acute process. (RX 4)

Dr. Yang re-examined Petitioner on December 13, 2013 noting a recent increase in pain. Petitioner continued to have limited range of motion of his shoulder due to pain and tenderness of the right elbow with limited range of motion. He was given prescriptions for hydrocodone, Flexeril, and Gabapentin and scheduled for a cervical epidural steroid injection with Dr. Randle. He was provided with a right arm trigger point injection and given a script for physical therapy after the injection. Petitioner was to remain off work through January 15, 2014. (RX 2, p. 4)

Petitioner continued to receive treatment from Dr. Carr and it was noted that he had undergone cervical steroid injections at C5-6 and C6-7. (RX 2, p. 4)

On January 7, 2014, at the request of Dr. Yang, Petitioner underwent a lumbar spine MRI. He completed an MRI Patient Data Sheet and did not respond to questions regarding whether his medical condition stemmed from an auto accident or workers' compensation injury. The History Sheet stated Petitioner had sustained an injury on 11/20/13 when he fell backwards into a manhole. He was complaining of low back pain with bilateral leg numbness and denied any prior surgery or MRI of his lumbar spine. The MRI revealed a circumferential bulge with a left far lateral annular tear at L4-5, mild lumbar spondylosis with facet arthropathy and mild right foraminal narrowing at L4-5 but no focal disc herniations or spinal canal stenosis. (RX 4)

On February 20, 2014 Petitioner presented to Dr. Kelly Cushing seeking care and help for anxiety. Petitioner presented with a history of chronic back pain due to an injury in 2008 for which he was undergoing steroid injections. Dr. Cushing noted that Petitioner had recently been seen in the ER at Washington University for a rash diagnosed as idiopathic urticarial. He had been discharged on Loratadine and Vicodin but didn't fill the script for Vicodin as he was already using it as prescribed by his neurologist, Dr. Randle, who he was seeing in Alton for his chronic back pain (cervical, right shoulder and lower back) who had been following him since 2008 for injury-related lower back pain. Petitioner was complaining of severe stress in his life due to his father's terminal illness and severe anxiety for which he had been under care by his primary care physician in Alton (whose name he could not recall). Petitioner was noted to be very vague with his history. Petitioner did not wish to leave a urine sample or undergo a blood draw due to anxiousness about his father. He received a series of phone calls and insisted he had to leave and would reschedule later. (RX 2, pp. 4-5; RX 7)

Petitioner continued treating with Dr. Carr. (RX 2, p. 5)

On March 27, 2014 Petitioner presented to Dr. Scott Purvines for neck, shoulder and right arm pain. Dr. Purvines' plan of care is not known.[1] (RX 2, p. 5)

Petitioner underwent an examination with Dr. Robert Backer on May 13, 2014 at the request of Respondent. (RX 8) Petitioner gave a history of being in an accident on November 20, 2013 (RX 8). Dr. Backer noted that Petitioner was not a good historian in providing the account. Dr. Backer diagnosed Petitioner with pain with range of motion in the right shoulder. He did relate to that to the work injury and stated that reasonable treatment was necessary. (RX 8). Dr. Backer recommended evaluation by an orthopedic surgeon and an MRI of the cervical spine. Dr. Backer also indicated that two previous MRIs had been done and needed to be compared to determine whether or not Petitioner would be in need of any additional treatment (RX 8). Dr. Backer indicated that Petitioner had no objective signs for any low back or right leg pain. Dr. Backer felt Petitioner's neck pain was related to his work injury. Dr. Backer noted ongoing complaints of low back pain and right leg pain but no objective signs on exam or by MRI to suggest any lumbar injury. He didn't think Petitioner needed any further low back care or treatment and that he was at maximum medical improvement for any low back complaints. He didn't render a causation opinion regarding Petitioner's low back; however, he documented Petitioner's history of low back pain and lower extremity complaints since the work accident. (RX 8).

Petitioner continued treating with Dr. Carr on May 20 and 22, 2014. (RX 2, p. 6)

Petitioner was seen at the emergency room at Barnes-Jewish Hospital on May 25, 2014 regarding complaints of neck, shoulder and arm pain of one year's duration. Petitioner complained of paresthesia, decreased sensation, and weakness in the right and intermittent paresthesia and decreased sensation to the bilateral feet following an accident in November of 2013. Petitioner reported being under the care of doctors since November but waking up that morning and being unable to move his neck past the midline on the right. Petitioner couldn't explain how much pain he was in and was noted to be agitated and uncooperative with the exam and not answering all the questions posed to him. He reported himself as a "case of insurance company run around....And what they do is pump you full of pain killers and try to put your surgery off." Petitioner said that "when it would get bad his body would go intro stress" and showed a picture of a rash on his thigh (on cell phone) He stated that the pain was located in the same area as his chronic pain but now more severe. X-rays were negative for fracture of the cervical spine or right shoulder. Petitioner didn't want to do blood work up again because he had been there a whole day one other time. Petitioner had taken two percocets while at x-ray as well as flexeril. He was discharged in stable condition with medications. (RX 2, p. 6; RX 7)

Petitioner was treated by Dr. Carr on May 28, 2014. (RX 2, p. 6)

Petitioner then had an MRI of the cervical spine on June 2, 2014 that showed degenerative disc disease and disc osteophyte complex at C4-5 and C5-6 resulting in mild central canal stenosis. There was also moderate right foraminal stenosis at C4-5 (PX 4; RX 2, p. 6).

Petitioner had treatment with Dr. Carr on June 6, 2014 and on June 25, 2014. (RX 2, p. 7)

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[1] Missing from the record. See page 5 of Dr. Lehman's report.

On July 8, 2014 Petitioner returned to Dr. Purvines's office. His discomfort was primarily in his neck and shoulder blades. He also had numbness and tingling in his elbow down to his hand. Activity worsened the complaints. Petitioner had undergone radiofrequency ablation of the cervical joints with no improvement. He had normal strength in his bilateral upper extremities with some slight decrease in sensation in the ulnar distribution of the right hand. He also had decreased range of motion in the right shoulder blade. They reviewed Petitioner's cervical MRI which showed "acute appearing" disc herniations in Petitioner's neck and very likely musculature injury of the right shoulder. Dr. Purvines recommended a shoulder evaluation before considering cervical spine burger and he recommended a two level anterior cervical discectomy and fusion as well as an EMG to look for an ulnar neuropathy at the elbow. (RX 2, p. 7)

The medical records from Barnes Jewish Hospital on July 9, 2014 confirm Petitioner presented there with complaints of severe right shoulder, neck pain and back pain and that the onset was sudden (RX 7). He arrived by ambulance having been involved in a motor vehicle accident. Petitioner had been traveling 15 or 30 mph and was a restrained drive. He denied loss of consciousness and was walking around at the scene of the accident and requested a backboard. He had a complete work-up and treatment including x-rays and CT diagnostics. Nothing acute was noted. Petitioner was diagnosed with strains and contusions and was prescribed Diazepam.(RX 7; RX 2, p. 7).

On July 24, 2014 Petitioner was examined by Dr. Thomas[2]. Dr. Thomas recommended an MR arthrogram of Petitioner's right shoulder and he imposed restricted duty. (RX 2, p. 8)

A right shoulder MRI was performed on August 6, 2014 and showed mild to moderate supraspinatus and infraspinatus tendinopathy without evidence of a full thickness rotator cuff tear along with degenerative changes. (RX 2, p. 8)

Petitioner continued to treat with Dr. Carr from August 18, 2014 through September 5, 2014 for cervical spine pain, low back pain, numbness and tingling. (RX 2, p. 8)

Petitioner returned to Dr. Purvines on September 11, 2014 in follow-up for his persistent neck and upper extremity discomfort. He denied any new symptoms, just ongoing persistence of his previous symptoms. It was noted that his symptoms were limiting him substantially and keeping him from getting back to work. Strength and sensation in his upper extremities was normal. Petitioner had ongoing decreased range of motion of his neck. (RX 2, p. 8)

Petitioner again treated with Dr. Carr from 9/24/24 through 11/4/14 with the patient noted to be "suffering a few setbacks due to an exacerbation in his symptoms." (RX 2, p. 8)

Medical records from December 1, 2014 from Barnes Jewish Hospital show that Petitioner presented with unbearable pain in his neck and right shoulder. He gave a history of being involved in an accident about a year earlier followed by involvement in a home invasion two weeks earlier with an aggravation of his pain. He also gave a history of working in his yard that day/the day before and now having worsening pain. Petitioner also stated he was waiting to get a disc replaced in his neck (previously scheduled for September but then needing to be rescheduled) and twisted wrong with worsening pain

[2] Dr. Lehman's summary notes that "His injury was reiterated to Dr. Thomas."

radiating down his right shoulder and arm. He also reported constant right hand numbness. (RX 7). Petitioner was discharged with no medications. (RX 7).

No medical records subsequent to December 1, 2014 were included in the record.

On January 28, 2015 Dr. Lehman issued a medical records review at the request of Respondent. He did not examine Petitioner. After a lengthy review of Petitioner's medical records [3] Dr. Lehman concluded as follows: (1) Petitioner's care and treatment to date had been reasonable; (2) The treatment, while reasonable, is not causally connected to Petitioner's accident at work; (3) The chiropractic treatment had been excessive and unrelated to the accident; (4) Petitioner's right shoulder complaints/condition was not related to the work accident and Petitioner required no further care for the shoulder; (5) Petitioner's current cervical spine condition was not related to the work accident but Petitioner did need further treatment; and (6) Petitioner's current lumbar condition was unrelated to the work accident. (RX 2)

The deposition of Dr. Scott Purvines was taken on May 14, 2015. (PX 4) Dr. Purvines is a board certified neurosurgeon who began treating Petitioner in March of 2014. At that time he took a history from Petitioner in which Petitioner related being engaged in his normal work activities when he fell into a hole and subsequently developed neck, shoulder and right upper extremity pain along with numbness extending down to the palms of his hand and his fingers (especially the ring finger). Petitioner had difficulty with range of motion on the right shoulder and neck discomfort extending down between his shoulder blades. All of the foregoing complaints were worse with use of his arm. Dr. Purvines believed that Petitioner had previously undergone both physical therapy and pain management before presenting to him. (PX 4, pp. 3-7)

Dr. Purvines conducted a physical examination which revealed neck tenderness extending down between the shoulder blades, painful range of motion (especially with flexion, right lateral rotation, and flexion) and numbness in his right hand. Petitioner did not bring his cervical MRI with him but in light of Petitioner's painful right shoulder range of motion the doctor felt a referral/evaluation by a shoulder specialist was appropriate. Dr. Purvines could not recall who Petitioner went to for the shoulder evaluation. However, he returned to see him thereafter and they ultimately reviewed the cervical MRI which was done on June 2, 2014. . Dr. Purvines testified that Petitioner had disc abnormalities at C4-5 and C5-6. He felt Petitioner's MRI findings at C4-5 were consistent with his complaints except for the right shoulder symptoms. Dr. Purvines also believed that Petitioner's complaints in his hand were consistent with a possible ulnar neuropathy. Dr. Purvines was under the belief that Petitioner had undergone a radio frequency ablation previously. When asked if the MRI showed disc herniations at C4-5 and C5-6, the doctor responded "Yes." (PX 4, pp. 7- 10)

Dr. Purvines testified that they discussed surgery for Petitioner's neck but he still recommended a shoulder evaluation before proceeding with surgery. (PX 4, p. 10)

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[3] The summary for which provided most of the medical back ground for this case as Petitioner's PX 3 containing many treatment records was not admitted

Petitioner returned to see Dr. Purvines on September 11, 2014 and they agreed to proceed with a C4-5 and C5-6 anterior cervical discectomy and fusion. (PX 4, pp. 10-11)

Dr. Purvines again examined Petitioner on December 16, 2014. At that visit Petitioner reported having undergone some sort of "traumatic episode" which the doctor could not exactly recall; however, since that event, Petitioner had been experiencing an increase in his familiar discomfort (ie.,. the same distributions as previously). Petitioner had even gone to the emergency room and Petitioner advised he was given some medication and discharged. (P 4, p. 13)

Dr. Purvines testified that Petitioner's symptoms are being generated by disc abnormalities at C4-5 and C5-6. He also believes there may be an issue with Petitioner's right shoulder and, possibly, his right elbow (ulnar neuropathy) which may or may not be related to the other issues. (PX 4, pp. 13-14) When asked if he had an opinion within a reasonable degree of medical certainty as to whether or not this accident history that he gave him of November 20, 2013 was the cause of the problems he presented with, the doctor replied, "I can say that it's consistent." (PX 4, p. 14) He explained that Petitioner's symptoms have remained consistent during their period of treatment. He has not released Petitioner to return to the work he had been doing. (PX 4, p. 14) He added that he hasn't seen any records that would make him believe Petitioner's symptoms aren't related but he doesn't do very much background investigation of his patients. Everything Petitioner told him seemed consistent with the story of his injury. (PX 4, p. 15)

On cross-examination Dr. Purvines testified that if he and Petitioner discussed any of Petitioner's history prior to November of 2013, he didn't record it. He didn't recall doing so. (PX 4, pp. 16-17) He agreed that Petitioner denied any permanent relief from the injections or the physical therapy. He did not recall if he reviewed any of those records. (PX 4, p. 17) Petitioner did not report any history of neck pain before November 20, 2013 but the doctor testified that he probably didn't ask him about it. They also did not discuss any further injuries. (PX 4, pp. 17-18)

Dr. Purvines acknowledged that he only saw the June 2, 2014 MRI and if there were others that had been done he didn't record it. He also acknowledged that throughout the time he has been treating Petitioner he could not recall whether or not he gave Petitioner work restrictions. (PX 4, pp. 22-23) His reports did not state anything. (PX 4, p. 23) He believed his Summary Report of September 11, 2014 might have indicated he couldn't work. (PX 4, p. 23) Dr. Purvines acknowledged that he has not seen any records from Alton Memorial Hospital other than a January 7, 2014 lumbar MRI and a November 25, 2013 cervical MRI. He could not recall that Petitioner ever mentioned a car accident occurring on May 16, 2008. He had not seen a CT scan of Petitioner's cervical spine dated May 16, 2008, any records from St. Anthony's Health Center from November of 2009, or any information pertaining to a tree falling on him in November of 2009. Dr. Purvines was also unaware of a December 3, 2009 cervical spine MRI. Petitioner had never told him that he had been diagnosed with a mild bulging disc at C4-5. He did not compare any MRIs pertinent to Petitioner's neck. He was also unaware that Petitioner

had fallen down some stairs on November 1, 2011. When asked if it would alter his opinion if he had the previous MRIs from 2009 and 2011 Dr. Purvines testified, "That's a difficult question to answer since I haven't seen them. In my opinion the new MRIs demonstrate an acute abnormality, however, that likely isn't years old." (PX 4, pp. 28-29)

On redirect examination Dr. Purvines explained that there were certain MRI characteristics suggestive of recent soft tissue injury. It was his understanding that Petitioner was performing heavy labor work at the time of his accident and wasn't having any problems at all until after that accident. (PX 4, pp. 29-30) He has never released or recommended that Petitioner return to work. (PX 4, p. 30)

The deposition of Dr. Lehman was taken on June 24, 2015. Dr. Lehman testified to decades of experience as an orthopedic surgeon (RX 1). Dr. Lehman testified that he reviewed all the medical records in this case in January of 2015. He noted significant clinical findings for previous shoulder and cervical spine pain associated with a prior motor vehicle accident, prior injury involving a fallen tree striking Petitioner's back and cervical MRIs that demonstrated degenerative changes at C5-6 (RX 1). Dr. Lehman testified that with respect to Petitioner's neck issues and review of the MRI's, that Petitioner had foraminal stenosis and entrapment of the exiting nerve (RX 1). Dr. Lehman noted Petitioner had fallen into a hole and had been evaluated for the fall on March 27, 2014.

Dr. Lehman testified that Petitioner had long term facet arthropathy which began in 2009 and increased between 2009 and 2011 (RX 1). This was long-term condition that did not change after Petitioner's alleged accident in 2013 (RX 1). Dr. Lehman concluded the Petitioner's 2013 accident had no causal relationship to his condition because he did not suffer any acute changes in his condition (RX 1). Petitioner did not even experience any further degenerative changes since the previous evaluations predating the accident (RX 1).

Dr. Lehman testified that his conclusions with respect to the cervical spine were based on review of the MRI scans and that there was no causal relationship between the medical records and there had been similar levels in pathology of progression in the scans that were previously taken in 2009 and 2011 (RX 1). Dr. Lehman testified Petitioner's treatment was not medically causally related to Petitioner's accident and did not require any work restrictions to the cervical spine and lumbar spine or right shoulder in relation to this accident (RX 1). The doctor felt that Petitioner's current limitations were not related to his accident. (RX 1).

Petitioner's case proceeded to arbitration on July 30, 2015. Petitioner was the only witness testifying at the hearing. The disputed issues were accident, causal connection, medical bills, temporary total disability benefits, prospective medical care, and penalties and attorney's fees. During the hearing several evidentiary issues were raised which were also taken with the case.

Petitioner testified that on November 20, 2013 he was working for Respondent. He had worked there three months prior performing concrete work and highway work

Petitioner testified that on the day of the alleged injury, he was shoveling concrete and building curbs for handicapped sidewalks. Petitioner testified that there was another employee for Respondent

working with him; however, he couldn't recall his name. On November 20th, it was about to rain, so they were going to cover the area with plastic to protect the concrete. Petitioner testified that as he grabbed the plastic to stretch it out, his leg went into an uncovered sewer grate. Petitioner testified that his right leg, back, right shoulder and neck went backwards and landed on his right side on the ground. Petitioner continued working until he was done for the day. Petitioner testified that at the time of accident, his right leg, lower part of his back, right shoulder, and neck all went backwards. As he explained it, his left leg was on top of the road surface; his right leg was inside the hole. He mainly landed on his right elbow and "flipped backwards" because he was walking backwards. Petitioner testified that his foreman asked him if he was okay and he responded that he didn't know yet. His foreman then had him go since it was raining. Petitioner also testified that "a first person" told him to go get it checked out.

Petitioner testified he went to see Dr. Carr on November 20, 2013.

Petitioner testified he saw Dr. Gregory Randle who did a series of injections and nerve blocks. Dr. Randle is associated with Vigilant Pain Managements. Petitioner testified he continued to treat with Vigilant Pain Management. Petitioner presented no medical records or evidence from Vigilant Pain Management to support any treatment.

Petitioner testified that Dr. Randle recommended and scheduled him for surgery in September. His attorney then asked him if Dr. Purvines scheduled the surgery and Petitioner responded "Yes."

Petitioner acknowledged being seen by Dr. Backer at the request of Respondent's insurance carrier.

Petitioner testified he then went to see Dr. Purvines at St. Luke's Hospital Brain & Spine Institute in September 2014.

Petitioner testified on July 9, 2014 he was involved in a motor vehicle accident. Petitioner testified to right shoulder, neck and back injuries when seen at the ER.

Petitioner testified that he was involved in a car accident on August 25, 2014. He was hit by another vehicle that ran him off side of the road and came in contact with a pole.

Petitioner testified that he was involved in a home invasion in mid-November 2014. He claimed that there were two men in his home and they exchanged words and yelled. Petitioner testified that he hit his left shoulder.

Petitioner also testified he had an injury on December 1, 2014 while he was working in his yard at home. He had an injury to his neck, right shoulder and arm while twisting his body, picking up windows, screens and pine tree limbs. Petitioner further testified that his neck was messed up from his car accident.

Petitioner also acknowledged having a prior injury while working on the hospital extension in Alton. However, he had no lost time from work; rather, he worked light duty.

Petitioner acknowledged treating with Dr. Carr prior to November 21, 2013 and that the treatment went back to when he got hurt on the Alton hospital job and was on light duty.

Petitioner testified to being arrested on October 17, 2013 by Missouri State Highway Patrol. Petitioner testified he was arrested for possession of controlled substances. Petitioner refused to answer whether or not he was arrested for being in possession of methamphetamines. Petitioner also refused to answer whether or not he was arrested for possession of Alprazolam. Petitioner further refused to testify and answer whether or not he was arrested for possession of Diazepam. Petitioner pled the Fifth Amendment at trial.

Petitioner testified that he hasn't undergone surgery as every time it is scheduled, it gets cancelled. Petitioner continues to experience bad pain in his neck, right shoulder and down through his right arm. Petitioner believes he may have a muscle problem in his shoulder and an ulnar nerve problem in his elbow. He described his neck pain as intense. His elbow feels like it is on fire. The arm pain going from his bicep to his elbow feels thick and hot. Petitioner's fourth and fifth fingers on the right hand are always numb as is the pad. He has good days and bad days.

Petitioner brought his medications with him to the hearing and testified that they have been prescribed by Dr. Randle. Petitioner has lost weight as Dr. Purvines suggested it in order to have a quicker recovery.

The Arbitrator concludes:

With regard to Issue (C), Did an accident occur that arose out of the course of Petitioner's employment by Respondent?:

Petitioner sustained an accident on November 20, 2013 that arose out of and in the course of his employment. Petitioner's testimony on the issue of accident was unrebutted and corroborated by the histories provided to the various medical providers. Petitioner testified that a co-worker (a shop worker for Respondent) was with him at the time of the accident and interacted with him thereafter. Petitioner also testified to speaking with his foreman. Respondent offered no rebuttal witnesses. Petitioner was both in the course of his employment and his injury arose out of his employment.

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

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

Petitioner failed to prove that his current condition of ill-being in his neck, right shoulder, and right arm is causally related to his November 20, 2013 accident. Petitioner failed to meet his burden of persuasion on causation or that his need for surgery is causally related to the work accident. In support thereof the Arbitrator notes the following.

1. Petitioner's credibility. Petitioner was not an altogether credible witness. From the beginning of his testimony there were inconsistencies. For example, he testified that the same day as the accident he presented to Dr. Carr. Keeping in mind that Dr. Carr's records were not a part of the record, the only reference to them is found in Dr. Lehman's IME report and Dr. Backer's IME report. According to it, Petitioner presented on November 21, 2013, the day after his accident. Petitioner also only claimed left shoulder injuries as a result of the home invasion episode at his house in

2014; however, the medical records indicate differently. Petitioner also provided some very confusing testimony regarding who recommended and scheduled his back surgery. At first he testified it was Dr. Randle. His attorney then brought up Dr. Purvines. None of it was flushed out. This was very troubling to the Arbitrator in light of Petitioner's representations to Dr. Cushing in February of 2014 wherein the doctor clearly noted that Petitioner had a history of chronic back pain due to an injury in 2008 for which he was undergoing steroid injections. Petitioner did not mention the accident with Respondent herein whatsoever. Petitioner further told Dr. Cushing that he was seeing Dr. Randle since 2008 for his chronic back pain (cervical, right shoulder, and low back). Dr. Randle's records aren't a part of the record. Petitioner provided no testimony in an effort to sort all of this out or explain it.

Petitioner also was not truthful with Dr. Purvines. The doctor recommended surgery on September 11, 2014, to Petitioner's neck. (PX 4) Petitioner testified that he was involved in a motor vehicle accident on July 9, 2014. He was taken by ambulance from the scene and placed in a neck brace and back brace. In the emergency room, he complained of injuries to his right shoulder, back, and neck. Petitioner also had a motor vehicle accident on August 25, 2014. He testified that he was sideswiped by another driver running off the road. Petitioner did not give any history of either car accident to Dr. Purvines as it is not documented in the September 11, 2014 medical report or in any other records from Dr. Purvines. (PX 4) Petitioner further testified he was at the emergency room for neck pain on December 1, 2014. Petitioner testified his neck was messed up after his car accident. Petitioner also testified that he injured his right shoulder, neck and arm while working in his yard on December 1, 2014. The medical records read that on December 1, 2014, he was working in his yard and injured his neck, right shoulder and arm after twisting. Petitioner testified he was picking up pine tree limbs, storm windows and screens. Petitioner stated he was picking up more than one but less than 50. Again, Dr. Purvines did not have any of this information to accurately assess in his evaluation and treatment of Petitioner.

2. Missing records. Petitioner testified to treatment with a number of physicians and treatment facilities (ex. Vigilant Pain Management); yet, no records were admitted into evidence. The Arbitrator has had to try and put together a chronology of treatment based upon summaries from Respondent's examining physicians. The records themselves were never independently admitted. Petitioner admitted to treating with Dr. Carr before the accident and, yet, no medical records from Dr. Carr were admitted into evidence. While Petitioner testified to no lost time before his November 20, 2013 accident that doesn't mean he was asymptomatic. He acknowledged to several doctors that his complaints in 2014 went back to a 2008 accident and was chronic in nature.

3. Dr. Purvines' Testimony and Opinions. The Arbitrator did not find them persuasive. Dr. Purvines did not have a clear understanding and knowledge of Petitioner's prior medical problems in his neck. He did not review the earlier MRIs. In sum, he was rendering opinions without knowing all of the necessary information pertinent to Petitioner's case. Dr. Purvines testified that he had not reviewed all the medical records and did not review the prior MRI scans. He was not operating on all

knowledge associated with Petitioner's treatment. Dr. Purvines was not aware of any of the motor vehicle accidents involved. This is significant as his recommendation for surgery occurred on September 11, 2014 which was only two weeks after the second car accident on August 25, 2014.

The Arbitrator is aware that Dr. Backer issued an IME report at Respondent's request on May 13, 2014 and found causal connection for Petitioner's neck, right shoulder, and low back. However, even though Dr. Backer indicated Petitioner's neck pain was related to the work injury, Dr. Backer believed the petitioner should have had an MRI of the cervical spine to complete the work-up of his neck. Dr. Backer was aware of the two prior cervical MRIs and made it clear that those would need to be compared to the new MRI. Additionally, Dr. Backer's causation opinion was based on Petitioner's condition in May of 2014. The issue at the present time concerns Petitioner's current condition and whether an award of cervical surgery is in order. Dr. Backer did not address those issues.

With regard to Issue (J),Were the medical services provided to Petitioner reasonable and necessary and should Respondent pay all appropriate charges for all reasonable and necessary medical services:

Petitioner failed to meet his burden of proof on causation. Furthermore, to the extent medical bills may have been attached and included as part of PX 1, no supporting medical records were produced by the various treaters. Petitioner's request for an award of medical bills is denied.

With regard to Issue (L), What temporary benefits are in dispute, TTD?:

Petitioner failed to establish that he is entitled to TTD benefits from March 9, 2015, through July 30, 2015, as he failed to prove causation. Additionally, the Arbitrator notes that there are no off-work slips included in the record.

It is undisputed that Respondent paid $54,332.11 in TTD benefits and is entitled to a credit for all TTD paid to Petitioner.

With regard to Issue (M), Should any penalties or fees be imposed on Respondent?:

Consistent with her causation determination above, the Arbitrator denies penalties and fees to Petitioner. Even if Petitioner had prevailed on causation, the Arbitrator would have denied penalties and attorney's fees. Petitioner failed to establish that the denial of medical benefits, TTD, was unreasonable or vexatious. Respondent reasonably relied on the opinions of Dr. Lehman, as well as the substantial medical records submitted into evidence by Respondent. The Arbitrator also found Petitioner lacked credibility. Therefore, the denial of benefits does not rise to the level for penalties or fees and is denied.

With regard to Issue (N), Is Respondent due any credit (overpayment of TTD)?:

Respondent paid TTD benefits from November 20, 2013, through July 30, 2015 in the amount of $54,332.11; however, at the time of arbitration it denied liability for the benefits. Consistent with her causation determination, the Arbitrator awards Respondent a credit for all TTD benefits paid.

With regard to Issue (O), Whether the Police Report is admissible?:

R.X. 6 is not admitted as it constitutes hearsay.

The police report introduced at trial constitutes hearsay testimony, and therefore, should not be admitted. Even, assuming arguendo, it was admitted it concerns events pre-dating the alleged accident herein and has little probative value.

With regard to Issue (O), Whether Petitioner's Exhibits 6 and 6A- the Deposition Transcripts of Dr. Lehman in a prior civil case and his subsequent Curriculum Vitae are inadmissible?:

PX 6 and PX 6A are not admissible.

The Illinois rules of evidence apply to proceedings before the Illinois Workers' Compensation Commission ("IWCC"), "except to the extent they conflict with the act." 50 Ill. Admin. Code §7030 70(a) (2002). *See also, National Wrecking Co. v. Industrial Commission*, 816 N.E.2d 722 (2004). The controlling and relevant legal authorities resolving similar evidentiary issues in civil torts will also, therefore, be controlling and relevant in the workers' compensation context. The present question invokes issues that have been thoroughly treated by several well-established precedential and statutory authorities.

Depositions from prior cases may only be introduced at trial in later cases under specific circumstances. *Hubbert v. Dell Corporation*, 359 Ill.App.3d 976 (2005). Whether a deposition transcript can be admitted depends on whether [a] the party against whose interest the deposition testimony is being used had notice of the deposition and [b] [the party against whose interest the deposition testimony is being used had] an opportunity to cross-examine the deponent" (emphasis added). In *Hubbert*, Plaintiff introduced a deposition transcript from a different case over Respondent's objection. *Id.* The court held that "because there was no evidence that the defendant was a party to the [previous case] or that defendant's attorneys had notice or an opportunity to cross-examine [the deponent]…[the deposition was inadmissible]."

The facts of the present case fit squarely within *Hubbert's* framework. Respondent – the "party against whose interest the deposition testimony is being used -- had no notice of Dr. Lehman's previous depositions. Respondent, moreover, had "no opportunity to cross-examine" Dr. Lehman in Dr. Lehman's previous depositions. Petitioner may not, therefore, introduce the previous deposition transcript at trial.

Even if, *arguendo,* the depositions would not be precluded under *Hubbert*, the depositions would be heavily limited under the precedential and statutory rules governing the admissibility of discovery depositions generally. "Only rarely may any portion of a discovery deposition be used at trial." *Berry v. American Standard, Inc.*, 382 Ill.App.3d 895, 900 (2008).

Petitioner has tried to introduce Dr. Lehman's deposition testimony as an admission against Respondent's interest. Successful admission under this exception requires a finding that Dr. Lehman acts as an *agent* of Respondent. *Greaney v. Industrial Commission*. The court has held that a doctor retained by a respondent to conduct an Independent Medical Examination, and expert witnesses in general, "[are] not *per se* agent[s] of the party who hired him or her…" "[T]herefore, the expert's prior statements and opinions are not admissible as admissions against that party's interest."

PX 6 A is also rejected. It constitutes hearsay. Dr. Lehman was deposed and Petitioner's attorney did cross-examine him regarding the professional matter. The proper time to have presented the settlement agreement was during the doctor's deposition.

The Arbitrator finds that Respondent's objections to Petitioner's Exhibits 6 and 6A are sustained and the exhibits will not be admitted into evidence.

****

STATE OF ILLINOIS)
) SS.
COUNTY OF)
WILLIAMSON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Mary Jo Gilmore,

Petitioner,

vs.

NO: 11 WC 11826

State of Illinois/Central Management Services,

17IWCC0015

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, 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 March 23, 2016, is hereby affirmed and adopted.

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

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

DATED: JAN 19 2017
TJT:yl
o 12/19/16
51

Michael J. Brennan

Kevin W. Lamborn

DISSENT

In her decision, the Arbitrator cites *Peoria County Belwood Nursing Home v. Industrial Commission* (1987), 115 Ill.2d 524, 106 Ill.Dec. 235, 505 N.E.2d 1026, for the general proposition that accidental injuries due to repetitive trauma are compensable under the Act. The Arbitrator then goes on to state, in the same paragraph, that "[i]t is imperative, however, that Petitioner place into evidence specific and detailed information concerning his or her work duties, including the frequency, duration, manner of performing, etc. It is equally important that the medical experts have a detailed and accurate understanding of the Petitioner's work activities." (Arb.Dec.[Addendum], p.10). I can find and am not aware of any such "imperative" in *Peoria County Belwood* or its progeny.

Instead, the *Belwood* court noted only that "an employee who alleges injury based on repetitive trauma must still meet the same standard of proof as other claimants alleging an accidental injury. There must be a showing that the injury is work related and not the result of a normal degenerative aging process." *Peoria County Belwood*, 115 Ill.2d at 530. That burden of proof dictates a showing by a "preponderance of the credible evidence", not some abstruse "imperative" that mandates a heightened level of technical and ergonomic detail just to present a prima facie case.

Furthermore, it should be noted that "[b]y their very nature, repetitive-trauma injuries may take years to develop to a point of severity precluding the employee from performing in the workplace. An employee who discovers the onset of symptoms and their relationship to the employment, but continues to work faithfully for a number of years without significant medical complications or lost working time, may well be prejudiced if the actual breakdown of the physical structure occurs beyond the period of limitation set by statute. " *Oscar Mayer & Co. v. Industrial Commission*, 126 Ill.Dec. 41, 43, 176 Ill. App. 3d 607, 611, 531 N.E.2d 174, 176 (4th Dist. 1988). Indeed, as the appellate court noted, "[t]o always require an employee suffering from a repetitive-trauma injury to fix, as the date of accident, the date the employee became aware of the physical condition, presumably through medical consultation, and its clear relationship to the employment is unrealistic and unwarranted." *Oscar Mayer*, 176 Ill. App. 3d at 610.

With that in mind, I would find that Petitioner proved by a preponderance of the credible evidence that she sustained accidental repetitive trauma-type injuries arising out of and in the course of her employment, and that said injuries manifested themselves on or about 3/11/11, the date of the nerve condition study. The record shows that Petitioner worked as a court reporter for 40 years, a job that by its very nature demands repetitive and forceful use of the hands and wrists, particularly when using a stenography machine. Furthermore, while Petitioner admitted that she had first noticed symptoms as long as 20 years earlier, and the record reflects that she visited Dr. Davis seven (7) years prior to the date of the alleged accident with complaints of left hand and arm tingling, the fact of the matter is that she was released by Dr. Davis in June of 2005 after attending five (5) physical therapy sessions, and continued to work thereafter in her regular capacity as a court reporter for the following almost six (6) years, until she visited Dr. McElheny with worsening symptoms in both hands.

17IWCC0015

In addition, it does not appear that nerve conduction studies were performed in 2004-2005 in order to confirm a diagnosis of carpal tunnel syndrome. Likewise, while Dr. Davis noted that Petitioner understood carpal tunnel release was a possible treatment option, there is no indication that such a procedure was ever seriously considered, much less scheduled. More to the point, while both Petitioner and Dr. Davis obviously suspected her condition was related to her job as a court reporter, there is no evidence that Dr. Davis or any other physician ever actually voiced an opinion along these lines. Instead, Petitioner attended physical therapy and returned to work as a court reporter, which she continued to do until seeking treatment again in 2011.

Likewise, I would find that Petitioner provided proper and adequate notice of the accident to Respondent, based on a manifestation date of 3/11/11, and that a causal relationship existed between said accident and Petitioner's current condition of ill-being, based on the opinion of treating orthopedic surgeon Dr. Young. Along these lines, it should be noted that "[a]n 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." *Three "D" Discount Store v. Industrial Commission*, 144 Ill.Dec.794, 798, 198 Ill. App. 3d 43, 49, 556 N.E.2d 261, 265 (4th Dist. 1989).

As a result, I would reverse the Arbitrator and award compensation accordingly.

Thomas J. Tyrrell

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

GILMORE, MARY JO
Employee/Petitioner

Case# **11WC011826**

SOI/CENTRAL MANAGEMENT SERVICES
Employer/Respondent

17IWCC0015

On 3/23/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.44% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1167 WOMICK LAW FIRM CHTD
CASEY VANWINKLE
501 RUSHING DR
HERRIN, IL 62948

0558 ASSISTANT ATTORNEY GENERAL
AARON WRIGHT
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

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

0499 CMS RISK MANAGEMENT
801 S SEVENTH ST 8M
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

MAR 23 2016

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

17IWCC0015

STATE OF ILLINOIS)
)SS.
COUNTY OF WILLIAMSOM)

☐ 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)

MARY JO GILMORE
Employee/Petitioner

v.

STATE OF ILLINOIS/CENTRAL MANAGEMENT SERVICES
Employer/Respondent

Case # **11** WC **11826**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Christina Hemenway**, Arbitrator of the Commission, in the city of **Herrin**, on **January 14, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☒ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ 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, **March 11, 2011**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

In the year preceding the injury, Petitioner earned **$90,572.56**; the average weekly wage was **$1741.78**.

On the date of accident, Petitioner was **60** years of age, ***single*** with **0** dependent children.

ORDER

Petitioner failed to prove by a preponderance of the evidence that she sustained an accident that arose out of and in the course of her employment on March 11, 2011. All benefits are hereby denied. All other issues are moot and the Arbitrator makes no conclusions as to those issues.

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 21, 2016
Date

ICArbDec19(b)

MAR 2 3 2016

STATE OF ILLINOIS)
) SS
COUNTY OF WILLIAMSON)

17IWCC0015

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

MARY JO GILMORE
Employee/Petitioner

v.

Case #: 11 WC 11826

STATE OF ILLINOIS/CENTRAL MANAGEMENT SERVICES
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

On her date of accident of March 11, 2011, Petitioner was 60 years old, single, with no dependent children. She was employed by the State of Illinois/Central Management Services as a Court Reporter, primarily at the Johnson County Courthouse. She was so employed for 40 years, until her retirement on December 31, 2015. Petitioner testified that her normal work hours were 9:00 am to 4:00 pm, but that she did have to work later days when the Judge needed her in court. When she was not in court she was transcribing whatever transcripts were requested. Although she retired in December 2015, Petitioner testified she has recently gone back to work for the State in the same capacity, and will work up to 75 days a year on a per diem basis.

Petitioner testified she began having problems of tingling and discomfort with both arms and hands several years before she filed her worker's compensation case. She had tingling when she was driving a car and sometimes would have to take one hand off the wheel to rest it and just drive with one hand. She had trouble sleeping and the tingling and numbness would wake her up. It also bothered her at work but she testified she did not correlate anything at first, she just realized that the more she was in court the more it would bother her.

Petitioner testified that over the years her symptoms got worse and she eventually sought treatment in 2011 from her family physician, Dr. McElheny. He referred her to Dr. Alam for a nerve conduction study, which was done on March 11, 2011. He then referred her to Dr. Steve Young, a local orthopedic surgeon. Petitioner saw Dr. Young for her elbows and wrists on three occasions, beginning in April 2011. She confirmed that Dr. Young reviewed the nerve conduction study and diagnosed her with moderate to severe bilateral carpal tunnel syndrome and mild to moderate bilateral ulnar neuropathy. Dr. Young recommended surgery at that time.

On March 14, 2011, Petitioner filled out an accident report with Central Management Services, indicating her problem and condition, and advising she was seeking treatment for these conditions. She testified she still has not had the surgical procedures and that she continues to have the same symptoms. Over time the symptoms got progressively worse, to the point that she decided she needed to retire, which she did in December 2015. Petitioner testified she would like to get the problems fixed.

On cross-examination Petitioner acknowledged she had returned to work the week prior to trial, and had worked two eight-hour days. She testified she had the same symptoms on those days that she has had in the past and all along. Petitioner testified that when she worked full-time it was frequently for a judge who worked long hours, with a preference to keep going until the trial was done. She mentioned one trial in particular in which one night they went until 8:00 or 9:00 and the next night they went until 11:30. She admitted this particular instance occurred about 12 years ago; however, this particular judge did work long hours on a regular basis, which required her to work those hours as well. Petitioner testified she first had numbness and tingling many years prior to filing a claim, but did not realize what it was. She had had Lyme disease many years ago and at first thought it was maybe related to that. She finally went to Dr. McElheny because it was bothering her so bad she couldn't take it. She believes she first had the symptoms "as long as 20 years ago". Petitioner's hobbies include having chickens and thoroughbred horses. She currently has 17 horses she takes care of, but she does not ride them.

On February 26, 2004, Petitioner presented to Dr. Thomas Davis with Southern Orthopedic Associates, upon referral Dr. McElheny. She completed a "Patient Questionnaire", and listed complaints of tingling in her left arm and her left leg/tailbone and wrote "months" for when the complaints happened. She wrote she had similar complaints "a little on the right hand". When asked if this occurred at or as a result of work, she wrote "possibly", but indicated she did not have a worker's compensation claim involving the injury. Under Past Medical History, Petitioner checked that she had arthritis in her hands and fingers. She listed her occupation as Court Reporter for the State of Illinois and she listed her recreational pursuits as "horses (have 12)". She checked that she had numbness or tingling in her left leg and hand and swelling or painful joints in her knees and knuckles. RX2.

Dr. Davis performed an examination of Petitioner on February 26, 2004, and listed her chief complaints as left hand and arm tingling, as well as pain in her coccyx area for two weeks and chronic left foot numbness. He noted Petitioner was seen at the request of Dr. McElheny for evaluation of carpal tunnel symptoms of the left upper extremity. Petitioner had had progressive symptoms over the last two years. It was noted "she does a lot of keyboarding since she is a Court Reporter". Petitioner stated she had dropped objects with her left hand, had trouble opening jars, and combing her hair often exacerbated the tingling sensation in the hand. She stated the symptoms awaken her at night and she must rub the left hand to make them go away. She related that Dr. McElheny suggested she have neuroelectric studies prior to her appointment with Dr. Davis, but she heard they were painful and declined. She had not used splints or anti-inflammatories. Petitioner voiced concerns regarding hypothyroidism, in that she had gained twenty pounds in the last year. It was noted Dr. McElheny checked her thyroid in June (2003) and it was within normal limits. Dr. Davis noted Petitioner worked as a Court Reporter, was not a smoker, drank occasionally, and had twelve horses she cared for. On examination, Petitioner

had positive Tinel's sign at the left wrist and elbow and negative on the right. The Phalen's test was positive on the left and very mildly positive on the right for carpal tunnel disease. Based on all of this information, Dr. Davis's impression was bilateral carpal tunnel syndrome with the left greater than the right, mild cubital tunnel on the left, and lumbar spondylosis. Recommended treatment for her upper extremities was Celebrex and arm splints, as well as "neuroelectric studies of both upper extremities to document her carpal tunnel disease". He further noted, "She understands that surgery is available for carpal tunnel release. I advised her of risks, benefits, complications, and post op expectations regarding this surgery." RX2.

On April 27, 2004, there is a notation in Dr. Davis's chart that Petitioner had missed her appointment and a message had been left regarding her no show for the Nerve Conduction Study. She was instructed to call to reschedule that test, as well as a follow up with Dr. Davis. RX2.

Petitioner returned to Dr. Davis one year later, on April 28, 2005. She again completed a "Patient Questionnaire", listing her complaint as arthritic fingers. She wrote that the problem happened "over time" and that it happened "at work". In response to the question of how it happened, Petitioner wrote "continual beating hitting of Court Reporting keys". She listed previous similar problems or complaints as "carpal tunnel". When asked if it occurred as a result of work she wrote "yes" and when asked if there was a worker's compensation claim she wrote "Yes-possibly. Fingers are swollen and painful as a result of 29 years of Court Reporting." The chart note for April 28, 2005, states Petitioner came into the office and was not much better. She was requesting occupational therapy as the doctor ordered and to be off work until follow up in three weeks. A Leave of Absence Request Form from Administrative Services was completed, wherein Petitioner requested paid medical leave. Dr. Davis certified Petitioner was to be off work through May 27, 2005, was to do occupational therapy and to follow up with him on May 26, 2005. He listed the nature of disability as "OA hands". RX2.

On May 4, 2005, Petitioner presented to Occupational Therapy at Southern Orthopedic Associates for an evaluation. She reported pain in digits which occurred over the past years and has worsened. Under previous injury to extremity it was noted Petitioner had "CT" treated conservatively. It was noted she was off work from her job as a court reporter. She reported pain in her digits, mostly her left third digit, and reported she occasionally had sleep disturbance due to pain. She reported significant edema and trouble wearing jewelry. Petitioner participated in occupational therapy through May 26, 2005. RX2.

Petitioner returned to Dr. Davis on May 26, 2005, at which time it was noted that her fingers were better. She was given a return to work with restrictions of working six hours maximum a day for one month. On June 28, 2005, Petitioner followed up with Dr. Davis and reported that her symptoms had increased since she returned to work. She had not been taking anti-inflammatories. Her work slip indicated she should continue to work with restrictions indefinitely. (The Arbitrator notes this record is only partially legible.) RX2.

Medical records from Dr. Brian McElheny, Petitioner's primary care physician, were admitted into evidence. The records date back to 1987. Pertinent entries include May 22, 1997, July 23, 1998, April 12, 2007, and December 31, 2009. All of these entries make reference to the fact that Petitioner does a lot of heavy lifting with her hobby of horses. RX3.

Petitioner periodically returned to Dr. McElheny, her primary care physician, for various reasons between 2005 and 2007. On April 12, 2007, she presented with pain in her left forearm, primarily with supination, and pain in her left knee. It was noted she cared for quite a few animals and had to do a lot of lifting, which may be affecting both areas. She did not remember any trauma to either area. Dr. McElheny prescribed Feldene and recommended she use her right arm more than her left. Petitioner continued to see Dr. McElheny periodically throughout 2007, 2008, and 2009. On December 31, 2009, she presented with complaints of pain in her right shoulder and neck for three weeks. She reported she normally did a lot of lifting and tugging during the day. On May 24, 2010, she presented with complaints of pain in her neck and back following a motor vehicle accident. She saw Dr. McElheny periodically throughout 2010 and into 2011for various things, including her back. RX3.

On March 1, 2011, Petitioner presented to Dr. McElheny "with what she thinks might be bilateral carpal tunnel". It was noted she was employed as a court reporter and that she had been noticing recently that her hands would go numb at night. The discomfort was in the area of the thumb and first three fingers and would awaken her from sleep. On exam she had a positive Phalen's sign and a positive Tinel's sign bilaterally. Diagnosis was bilateral carpal tunnel, left worse than right. Dr. McElheny recommended a bilateral upper extremity nerve conduction study with Dr. Alam. On March 4, 2011, Dr. McElheny's chart reflects that an appointment was made with Dr. Gornet in Chesterfield, Missouri for March 31, 2011, for bulging discs. Petitioner was to "take work comp info and MRI film". RX3.

On March 11, 2011, Petitioner was seen by Dr. Fakhre Alam at SI Neurology & Sleep Medicine for EMG/NCS. It was noted she was referred to Dr. Alam by Dr. McElheny and by Dr. Steve Young, although it does not appear she had actually seen Dr. Young yet. She gave a history of having pain, numbness, and tingling involving her fingers and radiating up to her palms and wrist. It was noted she did not have diabetes mellitus or any history of prior neck injury or surgery. The electrodiagnostic study revealed moderate to severe bilateral carpal tunnel syndrome and mild to moderate bilateral ulnar neuropathy at the elbow. There was no evidence of cervical radiculopathy on either side. PX1, RX3.

On March 14, 2011, Petitioner completed a Workers' Compensation Employee's Notice of Injury. For date of injury she wrote "none specific". She did not indicate whether she had reported the injury to her supervisor Phil Ray, but wrote she "reported when diagnosed" when asked to explain why it was not reported on the date of incident. She indicated she has received medical treatment, which had been paid by Health Link. She reported she was performing her court reporting duties at the time of the injury, and that it had occurred in the courtroom and office. She reported the injury occurred "from continual use of hands (repetitive)". She described the injury as carpal and cubital tunnel to elbows and hands. She also indicated she had recently submitted a work comp claim for her back. Supervisor Phillip Ray completed a Supervisor's Report on March 21, 2011, indicating he was first aware of the reported injury on March 11, 2011. He confirmed Petitioner had been a court reporter for 34 years and that she was alleging repetitive injury to her hands. RX1.

On April 21, 2011, Petitioner presented to Dr. Steven Young at Southern Orthopedic Associates. She completed two forms, a Work History Questionnaire and a medical history. With regard to the Work History Questionnaire, she indicated her symptoms were pain, numbness, tingling, and stiffness in both hands equally and stated she had had these symptoms for a "long time". She indicated the numbness and tingling was in all fingers and thumb of the right hand and all fingers but not the thumb in the left hand. She stated she occasionally had pain in her neck and elbow, and that she had numbness and tingling in the forearm and elbow. She reported she had tried anti-inflammatories, steroid pills, and splints or braces "way back". She indicated she had been a Court Reporter for 35 years and listed her responsibilities as "taking down on steno machine everything said in court and then transcribing same on computer". She listed her work schedule as five to six days a week, eight hours a day. She indicated the more she was in court the worse her symptoms were, and that she noticed the increase as soon as she used her hands at work. She indicated her hobby was horses. PX2, RX2.

With regard to the medical history completed by Petitioner, she indicated she had previously seen Dr. Davis and further indicated this was a worker's compensation claim. Her complaint was carpal and cubital tunnel and she indicated the symptoms began a "long time ago". She described her pain as tingling and indicated that sleeping made it worse. She indicated she had arthritis and that she had an issue with her back. She listed her occupation as Court Reporter and indicated she was currently working. She indicated she did not smoke and did not drink much alcohol. She again indicated her recreational pursuit was horses. PX2, RX2.

Petitioner was examined by Physician's Assistant Kevin Rainey, as well as by Dr. Young on April 21, 2011. She gave a history of bilateral carpal tunnel and ulnar nerve symptoms and indicated she had been dealing with numbness and tingling in both arms and hands for the last ten years. She stated she had some pain and that the tingling is usually worse when sleeping. She conveyed she worked as a court reporter for the past 35 years. After examination, PA Rainey assessed bilateral carpal tunnel syndrome and bilateral ulnar nerve neuropathy, moderate to severe. He discussed surgical intervention versus conservative treatment and noted she had used splints in the past without much improvement. Surgery was discussed in detail. PA Rainey noted "her long work as a court reporter certainly has attributed to her above symptoms". An Addendum to the office note was provided by Dr. Young, who indicated he saw the patient along with PA Rainey. He concurred Petitioner had bilateral carpal tunnel syndrome and cubital tunnel syndrome. He noted "she is a court reporter and notes that these symptoms are exacerbated by her work situation". Her positive provocative signs and nerve study supported the diagnosis. The treatment plan was to perform left carpal tunnel release and left ulnar nerve transposition, and surgical risks, benefits, and prognosis were discussed. PX2, RX2.

On April 25, 2011, a nurse's note was made by Dr. Young's office indicating that she had been informed by their work comp department that the (initial) visit and further treatment was not work comp and would need to be done through the patient's personal insurance. The nurse left a message on Petitioner's cell phone to that effect. On April 28, 2011, a nurse's note was made that she had received a written note from the patient through the mail the she was going to wait on approval from work comp before going ahead with surgery. PX2, RX2.

Petitioner returned to Dr. Young on May 19, 2011. He noted she was last seen on April 21, 2011, at which time he recommended carpal tunnel release and ulnar nerve transposition on the left. Petitioner stated that the right upper extremity was actually bothering her more than the left, and she reiterated that her work activity has tended to greatly exacerbate her numbness and tingling. She again related that "her symptoms have been present for approximately 10 years". Examination of her right upper extremity revealed a positive ulnar nerve flexion compression test and Tinel's, and a positive median nerve flexion compression test and Tinel's. Dr. Young recommended carpal tunnel release and ulnar nerve transposition on the right, as opposed to the previously recommended procedures on the left, but indicated she would need both sides done. He stated, "As for cause, I do believe that her work situation could exacerbate her symptoms. I believe the fact that she is a 60-year-old female could have also contributed. PX2, RX2.

Dr. Young's medical record and Petitioner's testimony reveal the visit on May 19, 2011, was the last time Petitioner saw Dr. Young.

Dr. Young testified by way of deposition on July 10, 2012. He is a board certified orthopedic surgeon and has been in practice since 2001. The majority of his practice is based on treatment of hand and upper extremity problems. He testified consistent with his treating records for Petitioner. He opined to a reasonable degree of medical certainty that Petitioner's work activities likely exacerbated or caused Petitioner's symptoms of bilateral carpal tunnel syndrome and bilateral cubital tunnel syndrome. He recommended Petitioner undergo surgery on the left for both conditions, with potentially the right side to follow. He stated surgery had not been done to that point. PX3.

On cross-examination, Dr. Young did not recall if he had any other medical records to review in Petitioner's care and treatment. He did know, however, that in her chart there was a note from Dr. Tom Davis from February 26, 2004. That note stated Petitioner's chief complaint was left hand and arm tingling. He conceded it appeared that dating back to 2004 Petitioner had upper extremity symptomology similar to that for which she presented to Dr. Young in 2011. He did not recall if he had any records from Dr. McElheny, although that is who referred Petitioner for care in 2011. His initial record indicated Petitioner had utilized splints, and he confirmed that was prior to Petitioner presenting for care in April 2011. It was his impression that Petitioner was relating her symptoms to her job at that time. Dr. Young stated the basis for his opinion regarding causation was Petitioner's weekly activity, working on a steno machine or computer for eight hours a day, five to six days a week, combined with the duration of her occupation. He opined that early on with carpal tunnel syndrome rest could provide some relief or even some sort of a cure, but after it's been present for a long period of time, rest is probably not going to allow it to go away. PX3.

Dr. Young conceded there are orthopedic articles that discuss the relationship between keyboarding and the development of carpal tunnel syndrome and that there was some thought that there is no relation between the two. Dr. Young was not aware of whether or not Petitioner used any devices to aid in the proper placement of her hands when she used the steno machine or computer. He testified that the risk factors for the development of carpal tunnel syndrome are increasing age, female gender, obesity, diabetes, rheumatoid arthritis, low thyroid function, smoking, and hypertension. He further testified that Petitioner had three to four of these risk

factors, including being 60 years old, being female, having hypertension, and arguably being overweight at 5'5" and 175 pounds. Petitioner indicated in her medical history that she had arthritis but Dr. Young did not know in which areas she had arthritis. PX3.

Dr. Young acknowledged that on the morning of his deposition and prior to its start, he spoke with Petitioner, who indicated what she did for living on a daily basis. Prior to speaking with her, his understanding was she worked on a steno machine and a computer for five to six days a week, six to eight hours a day. Petitioner's records indicate, and Dr. Young recalled, that she had symptomology while she was sleeping. He explained this is a positional phenomenon related to nerve compression, in that it is related to the position in which an individual sleeps. He conceded that would not be related to Petitioner's job as a court reporter. PX3.

Dr. Young acknowledged that when Petitioner was first seen by PA Rainey on April 21, 2011, the history only indicates that her symptoms were brought on and worsened by sleeping, but there was no mention of them being worsened by work activities. Dr. Young confirmed that he had not seen Petitioner since May 19, 2011, and that she did not have any appointments scheduled. PX3.

Dr. Young was asked if his opinion regarding causation would change if Petitioner testified her hand activities at work were for less than six hours a day. He opined it would not, because she had had nerve compression for greater than ten years and any minimal amount of activity was probably going to exacerbate her symptoms or condition. He was aware she had had symptoms for at least ten years, according to Petitioner, and in looking at the note from Dr. Davis, she had had compression for at least eight years. With regard to Petitioner's examination by Dr. Davis of February 26, 2004, it was noted she was referred by Dr. McElheny for evaluation of carpal tunnel symptoms of the left upper extremity. She had had progressive symptoms over the last two years. It was noted she did a lot of keyboarding since she was a court reporter. Her tingling was limited to her left hand. Combing her hair exacerbated her symptoms and the symptoms awakened her at night. She had not utilized splints. Based on the examination, Dr. Davis diagnosed Petitioner with bilateral carpal tunnel syndrome, with left greater than right, and mild cubital tunnel syndrome on the left. He recommended treatment of arm splints and Celebrex, as well as nerve conduction study. There was also discussion about possible surgery. Dr. Young noted that keyboarding was mentioned, but there was no specific mention in the office note that that is what caused Petitioner's symptoms. Dr. Young again acknowledged that any activity of normal daily life may aggravate Petitioner's symptoms. PX3.

On February 11, 2013, Petitioner was examined by Respondent's Section 12 examiner, Dr. Patrick Stewart at Southern Illinois Hand Center. Dr. Stewart reviewed Petitioner's medical records, including the evaluation by Dr. McElheny of March 1, 2011, the EMG report from Dr. Alam of March 11, 2011, Dr. Young's records, the Employee's Report of Injury completed by Petitioner, the risk management services form and separate job duties form. Dr. Stewart took a history from Petitioner and conducted an examination. Petitioner reported her symptoms had been going on "for many, many years". She remembered a referral for some conservative modalities including splinting and therapy back in 2005 which helped her symptoms, but she had subsequent recurrences. She reported her hands fell asleep when she lifted overhead and she had a lot of nocturnal awakenings. She also reported some difficulty with dropping items. She

reported numbness and tingling in her thumbs and index and middle fingers, but was not sure regarding her small fingers. She recalled being treated with Prednisone in the past, probably for both her hands and her back. RX4.

Dr. Stewart asked Petitioner to reproduce the position she is in during stenography. She positioned her arms and he took measurements. Her elbow extension was 130 to 140 degrees. Her wrists were in a neutral to a slightly volar flexed position of ten degrees. RX4.

Following an examination of both upper extremities, Dr. Stewart diagnosed bilateral carpal tunnel syndrome, bilateral carpometacarpal arthritis with left pantrapezial arthritis and minimal thumb IP arthritis, and left cubital tunnel syndrome. Dr. Stewart opined Petitioner was not at maximum medical improvement and needed to be treated conservatively for her cubital tunnel syndrome. He recommended elbow pad positioning, as Petitioner got the most profound symptoms when she slept at night and kept her elbows in a flexed position. With regard to causation, Dr. Stewart referred to the position Petitioner was in during stenography, as demonstrated by her in the office. He also referred to the study by Mayo Clinic and the American Neurologic Society, in which they studied different risk factors for developing compression neuropathy with specific reference to data entry such as stenography and court reporting. The study did not reveal a significant increase of risk factor for patients developing compression neuropathies because of just the isolated data entry. In reference to the ulnar nerve at the elbow, Dr. Stewart noted if someone repeatedly flexes and extends their elbow or maintains their elbow in a hyperflexed position, this places increased pressure across the ulnar nerve. Dr. Stewart noted Petitioner made very clear the fact that she had the greatest symptoms when she was sleeping at night, and he opined this had the greater impact as far as the development of her condition. He noted as well the fact that Petitioner had medical comorbidities of being a woman and being perimenopausal. RX4.

Dr. Stewart testified by way of deposition on February 4, 2014. He is a board certified surgeon, with added certification in Hand Surgery. His medical practice is primarily treating and evaluating patients with hand and upper extremity problems and he performs surgery to those areas about three days per week. Only about one percent of his practice is dedicated to Independent Medical Exams and/or records reviews, with the remaining portion dedicated to patient care. He treats patients with carpal and cubital tunnel syndrome, including performing surgeries for those conditions, in the normal course of his practice. Dr. Stewart confirmed certain medical conditions increase the risk for development of these, including diabetes, thyroid dysfunction, rheumatoid arthritis, pregnancy, renal failure, hypertension, obesity, and being a perimenopausal woman. The medical literature specifically references two occupations which significantly increase the risk of developing carpal tunnel syndrome, which are meat cutting and forestry. The reason is they both have the multiplicity of risk factors, which include forceful and repetitive activities, vibration exposure, and cold exposure. With regard to occupations which increase the risk of developing cubital tunnel syndrome, it would be those occupations which require specific elbow positions or repetitive elbow action. RX4.

Dr. Stewart testified consistent with his report of February 11, 2013, following his examination of Petitioner. He reviewed her records prior to the exam, gave a synopsis of the records, and allowed Petitioner to comment on that synopsis. Dr. Stewart found it noteworthy

that the records were inconsistent with regard to whether Petitioner had numbness and tingling in her small fingers, and she was not confident during his examination that she had that symptom. Dr. Stewart testified that carpal tunnel syndrome never makes the small finger go numb, so when someone has symptoms in the small finger there is concern about the ulnar nerve, which is more commonly compressed at the elbow than at the wrist. The electrodiagnostic study showed minimal cubital tunnel syndrome on the right, and was normal on the left. In addition to medical records, Dr. Stewart reviewed a job description for the class specification of "Official Court Reporter II", as well as a "Demands of the Job" form, both provided by Respondent. RX4.

On the date of Petitioner's exam, Dr. Stewart saw her on two separate occasions. He initially saw her, went over the synopsis of the medical chart, and performed a physical exam. He then referred her to the practice's therapy department for additional testing with regard to her sensibility within her hand, what she was feeling and what she was reporting. He then saw her back and went over the results with her. He also obtained x-rays because of complaints Petitioner had in her thumb joints. Dr. Stewart estimated Petitioner was in the office one to one and a half hours and actually in the exam room with him for about thirty minutes. RX4.

Dr. Stewart took a history from Petitioner, who reported this problem had been going on for many years. She recalled splinting and some conservative treatment as far back as 2005. She had resolution of her symptoms but subsequently had recurrence. When asked when she was most aware of her symptoms or most symptomatic, she related she had nocturnal awakenings that were constantly occurring, and also noted her hands fell asleep whenever she lifted them over her head. She also felt she was starting to drop some items. RX4.

Dr. Stewart had Petitioner demonstrate what position she did her work in and that was most comfortable to her. There was nothing of significance in her positioning, with the exception that her wrists were slightly flexed rather than at neutral or slightly extended. RX4.

With regard to the study by Mayo Clinic referenced in his report, Dr. Stewart noted this particular study was different from other studies in that they did a questionnaire and also an EMG, rather than just a questionnaire. The authors expected the study to confirm that data entry and repetitive activities would show a significant increase in the risk of developing carpal and/or cubital tunnel syndrome as compared to the general population and it did not. RX4.

Dr. Stewart's diagnoses of Petitioner were bilateral carpal tunnel syndrome, arthritis in her thumbs with left more advanced than right, and symptoms of cubital tunnel syndrome on the left. He testified Petitioner's gender as a woman placed her at an increased risk of developing carpal and cubital tunnel syndrome, as did her age and hypertension. He opined within a reasonable degree of medical certainty that Petitioner's job did not cause or contribute to her carpal tunnel or cubital tunnel syndromes. RX4.

On cross-examination, Dr. Stewart confirmed that the study completed by Mayo Clinic and produced in conjunction with the American Neurologic Society was based on typing and data entry of up to seven continuous hours. Dr. Stewart acknowledged that typing and data entry are similar to a court reporter's work, but that there would be some variability in utilizing a steno machine versus a computer keyboard or typewriter. He further testified that is why he asked

Petitioner to demonstrate for him the position she was in while performing her job. Dr. Stewart described hyperflexion as going beyond 90 degrees. If the arm is straight, that is 180 degrees. As the arm comes up, the total arc of the arm movement is usually between 120 and 140 degrees. As the arm comes up, beyond 90 degrees is referred to as hyperflexion. Hyperflexion is a contributing factor to cubital tunnel. Dr. Stewart testified that this was not the position Petitioner was in when she demonstrated for him. Rather, her extension was 130 to 140 degrees and her arms were much closer to being straight than to being fully bent. She was only 40 degrees from full extension. RX4.

CONCLUSIONS OF LAW

The Arbitrator hereby incorporates by reference the above Findings of Fact, and the Arbitrator's and parties' exhibits are made a part of the Commission's file. After review of the evidence and due 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 which arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator finds the following:

As a general rule, repetitive trauma cases are compensable as accidental injuries under the Illinois Worker's Compensation Act. In Peoria County Belwood Nursing Home v. Industrial Commission (1987) 115 Ill.2d 524, 106 Ill.Dec. 235, 505 N.E.2d 1026, the Supreme Court held that "the purpose behind the Workers' Compensation Act is best served by allowing compensation in a case...where an injury has been shown to be caused by the performance of the claimant's job and has developed gradually over a period of time, without requiring complete dysfunction...." It is imperative, however, that Petitioner place into evidence specific and detailed information concerning his or her work duties, including the frequency, duration, manner of performing, etc. It is equally important that the medical experts have a detailed and accurate understanding of the Petitioner's work activities.

Petitioner is claiming an injury to both arms and wrists due to repetitive work activities. In Illinois, recovery under the Worker's Compensation Act is allowed, even though the injury is not traceable to a specific traumatic event, where the performance of the employee's work involves constant or repetitive activity that gradually causes deterioration of or injury to a body part, assuming it can be medically established that the origin of the injury was the repetitive stressful activity and that it manifested itself within the statute of limitations.

The Arbitrator finds that Petitioner failed to prove by a preponderance of the evidence that she sustained accidental injuries on March 11, 2011, that arose out of and in the course of her employment with Respondent. In so concluding, the Arbitrator finds significant that Petitioner had had symptoms of numbness and tingling in her hands and elbows for more than seven years at the time she filed her claim. This is uncontroverted, and was confirmed by Petitioner's own testimony.

Petitioner first sought medical attention for her complaints of numbness and tingling in early 2004. Her primary physician, Dr. McElheny, referred her to Dr. Dr. Tom Davis, and she

was examined by him on February 26, 2004. At that time she indicated she had had progressive symptoms over the last two years. She reported that combing her hair often exacerbated the tingling, that she had trouble opening jars, and that the symptoms awakened her at night. She had positive Tinel's sign at the left wrist and elbow, negative on the right, and positive Phalen's sign on the left and mildly positive on the right for carpal tunnel. She was diagnosed with bilateral carpal tunnel syndrome, left greater than right, and mild cubital tunnel syndrome on the left. Surgery was discussed at that time. Petitioner testified that she first had numbness and tingling many years prior to filing a claim, but did not realize what she had. Dr. Davis's records clearly indicate otherwise, and the Arbitrator finds Petitioner to not be credible on this issue. She returned to Dr. Davis on April 28, 2005, indicating she was not much better, at which time she participated in a short course of therapy and was taken off work. She reported continued sleep disturbance due to pain.

When Petitioner presented for treatment to Dr. McElheny on March 1, 2011, she indicated she was there "with what she thinks might be bilateral carpal tunnel". She indicated she was employed as a court reporter, but further indicated that she had been noticing that her hands go numb at night and that it will awaken her from sleep. She had positive Tinel's sign and Phalen's sign on both sides and was diagnosed with bilateral carpal tunnel syndrome, left worse than right. The Arbitrator notes this was the same diagnosis made by Dr. Davis in 2004 and 2005, and Petitioner's complaints and symptoms were the same. The Arbitrator further notes and finds suspect that this examination temporally correlates with Petitioner having reported a worker's compensation injury to her back, as evidenced by her Employee's Report of Injury for this claim. (RX1).

Petitioner saw Dr. Young on two occasions in 2011. He testified that Petitioner's upper extremity symptomology in 2004, when she was seen by Dr. Davis, was similar to that for which she presented to him in 2011. He further testified that it was his understanding Petitioner worked on a steno machine or computer five to six days a week for eight hours a day, yet he made no inquiry with Petitioner as to whether she used any devices to aid in the proper placement of her hands when she used either machine. There is further no indication that he had Petitioner demonstrate for him the position she is in during her stenography. Dr. Young testified Petitioner has several risk factors associated with the development of carpal tunnel syndrome, including her gender, her age, her weight, and her hypertension. Dr. Young further testified that Petitioner's symptomology when sleeping was a positional phenomenon related to nerve compression, and specifically the position in which she sleeps. Finally, Dr. Young testified that Petitioner has had nerve compression for greater than ten years and that any minimal amount of activity, including activities of daily living, is probably going to exacerbate her symptoms or condition.

Petitioner reported to Dr. Stewart that her symptoms had been going on for "many, many years", dating back to around 2005. She further reported that her hands fell asleep when she lifted overhead and that she had a lot of nocturnal awakenings. The Arbitrator notes that there is nothing in the record which would indicate that Petitioner does any overhead lifting with her job as a Court Reporter. Rather, the Arbitrator finds significant that all of Petitioner's records indicate that she cares for quite a few animals, including 17 horses at the time of trial. Dr. McElheny's records show several entries which refer to Petitioner doing a lot of lifting and tugging in connection to taking care of the animals, including horses.

Dr. Stewart performed a thorough examination of Petitioner. He also had Petitioner reproduce and demonstrate for him the position she is in during stenography, and he took measurements while she was in this position. He testified that her hands were positioned neutral to a little flexed (ten degrees) and that her arms were much closer to a straight position than to being fully bent. Based in part on the demonstration and measurements, Dr. Stewart opined that Petitioner's job did not cause or contribute to her carpal tunnel syndrome or cubital tunnel syndrome. Dr. Stewart also based his opinion in part on the study conducted by Mayo Clinic and produced in conjunction with the American Neurologic Society. That study found that those who did data entry or typed for up to seven continuous hours a day were not at any increased risk of developing carpal tunnel syndrome beyond that risk to the general population. The Arbitrator finds significant that during Dr. Young's testimony, he acknowledged the conclusions of this study and did not challenge them or otherwise comment on them. Dr. Stewart found Petitioner's job similar to those in the study, but recognizing some variability in utilizing a steno machine versus a computer keyboard or typewriter, he found it important for Petitioner to actually demonstrate the position she was in while using the steno machine. Having found her positioning to be neutral, he opined her job did not cause or contribute to her conditions. He further found Petitioner to have the same comorbidities that Dr. Young found, namely her gender, her age, her weight, and her hypertension. Dr. Stewart also opined that Petitioner made it very clear that she had the greatest symptoms when she was sleeping at night, and that this had the greater impact on the development of her condition.

The Arbitrator finds persuasive Dr. Stewart's opinion that Petitioner's job did not cause or contribute to her conditions. His examination was very thorough and included a demonstration by Petitioner herself as to her positioning while using the steno machine. In addition, he reviewed Petitioner's actual job description for "Official Court Reporter II" as well as the CMS Demands of the Job form, provided by her employer. The Arbitrator is disinclined to rely upon Dr. Young's causation opinion, in that it does not appear he had a detailed and accurate understanding of Petitioner's work activities, and certainly not as thorough of an understanding as did Dr. Stewart.

The Arbitrator finds significant that both Dr. Young and Dr. Stewart found Petitioner to have several comorbidities which increased her risk of developing both carpal tunnel syndrome and cubital tunnel syndrome.

It is uncontroverted that Petitioner had symptoms of tingling and numbness for at least seven years prior to filing this claim. Her symptoms did not change, other than to naturally progress, and her diagnosis and recommended treatment did not change.

Based on the foregoing and the record in its entirety, the Arbitrator concludes that Petitioner failed to prove by a preponderance of the evidence that she sustained an accidental injury which arose out of and in the course of her employment on March 11, 2011. Further, were the Arbitrator to have found an accident, said accident would have manifested in 2004, and would thus be barred by Section 6(d). All benefits are denied. The remaining uses are moot and the Arbitrator makes no conclusions as to those issues.

STATE OF ILLINOIS)
) SS.
COUNTY OF WILL)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Brian Cox,

Petitioner,

vs. NO: 14 WC 19732

17IWCC0016

FMC Corp.,

Respondent.

DECISION AND OPINION ON REVIEW

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

The Commission clarifies the Arbitrator's decision to find that Petitioner failed to prove that his condition of ill-being subsequent to 3/1/14 was causally related to the accident on 1/23/14 based on the opinion of Dr. Van Fleet. To the extent that the Arbitrator intimates that Petitioner may have suffered an intervening accident following a waterline break at his home prior to his visit to the emergency room on 5/7/14, the Commission notes that there is no evidence of any specific incident to support such a finding. Instead, the Commission finds persuasive Dr. Van Fleet's opinion to the effect that Petitioner suffered a strain of his back on the date of the accident, that said injury had resolved itself and Petitioner had reached MMI as of 3/1/14, and that Petitioner's subsequent complaints were more likely the consequence of his underlying degenerative disc disease as well as obesity. (RX1, pp.13,23-24). Furthermore, the

17IWCC0016

Commission finds it significant that Petitioner was released and in fact returned to work without restrictions on 3/1/14 in his previous job of operator and continued to work for Respondent in this capacity, without seeking additional treatment, until his visit to the emergency room more than two (2) months later on 5/7/14, at which time he provided a history of the onset of symptoms the night before. (PX6). Based on the above, the Commission finds that Petitioner failed to prove by a preponderance of the credible evidence that his condition of ill-being subsequent to 3/1/14 was causally related to the accident on 1/23/14.

Furthermore, the Commission notes that at the commencement of trial, the parties submitted into evidence a Request for Hearing form wherein they agreed that the nature and extent of the injury was not in dispute "unless a finding is made for Respondent." (Arb.Ex.#1). The Arbitrator subsequently issued a decision pursuant to §19(b) and §8(a) of the Act which did not address the issue of permanency. The Commission finds that the Arbitrator's decision to forego a determination as to nature and extent at this juncture was entirely proper and within her discretion, given the various issues in dispute. Along these lines, it should be noted that the parties cannot by stipulation bind the Commission. See *Lusietto v. Industrial Commission*, 174 Ill.App. 3d 121, 528 N.E.2d 18, 123 Ill.Dec. 634 (3rd Dist. 1988). Accordingly, Respondent's request for a determination as to permanency is denied, and the matter is remanded to the Arbitrator for further proceedings pursuant to *Thomas v. Industrial Comm'n*, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

All else is otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed 12/4/15 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.

The party commencing 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 19 2017
o: 11/29/16
TJT/pmo
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

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

COX, BRIAN
Employee/Petitioner

Case# **14WC019732**

FMC CORP
Employer/Respondent

17IWCC0016

On 12/4/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.41% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0980 HASSELBERG WILLIAMS GREBE ETAL
KENNETH M SNODGRASS
401 W MAIN ST SUITE 1400
PEORIA, IL 61602

1120 BRADY CONNOLLY & MASUDA PC
SURABHI SARASWAT ESQ
10 S LASALLE ST SUITE 900
CHICAGO, IL 60602

17IWCC0016

STATE OF ILLINOIS)
)SS.
COUNTY OF WILL)

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

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

Brian Cox
Employee/Petitioner

v.

FMC Corp.
Employer/Respondent

Case # **14** WC **19732**

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 **September 22, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, January 23, 2014, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $35,610.12; the average weekly wage was $684.81.

On the date of accident, Petitioner was 32 years of age, *single* with 3 dependent children.

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

Respondent shall be given a credit of $0 for TTD, $368.00 for TPD, $0 for maintenance, and $8,645.45 for other benefits (i.e. non-occupational indemnity benefits), for a total credit of $9,013.45. *See* AX1.

Respondent is entitled to a credit of $2,085.67 under Section 8(j) of the Act.

ORDER

As explained in the Arbitration Decision Addendum, the Arbitrator finds that Petitioner's condition of ill-being in the lumbar spine is causally related to his accident at work through March 1, 2014 as opined by Dr. VanFleet.

Temporary Total Disability Benefits & Prospective Medical Treatment

Petitioner's claim for temporary total disability benefits from May 7, 2014 through September 22, 2015 is denied and Petitioner's claim for prospective medical care as prescribed by Dr. Kube is denied.

Medical Benefits

Respondent shall pay reasonable and necessary medical services as reflected in Petitioner's Exhibits that remain unpaid for medical treatment through March 1, 2014 pursuant to the medical fee schedule as provided in Sections 8(a) and 8.2 of the Act. Petitioner's claim for payment of medical bills for treatment rendered after March 1, 2014 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

November 24, 2015
Date

DEC 4 - 2015

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

Brian Cox
Employee/Petitioner

v.

FMC Corp.
Employer/Respondent

Case # **14** WC **19732**

Consolidated cases: **N/A**

FINDINGS OF FACT

The issues in dispute are causal connection, Respondent's liability for certain unpaid medical bills, Petitioner's entitlement[1] to temporary total disability benefits from May 7, 2014 through September 22, 2015, and whether he is entitled to prospective medical care in the form of a dorsal column stimulator and other concordant medical treatment as ordered by Dr. Kube. Arbitrator's Exhibit[2] ("AX") 1.

Background

Petitioner testified that he was an Operator for Respondent on January 23, 2014 when he was injured at work. He explained that he operated a machine that produced herbicides and pesticides. Petitioner testified that he mixes base chemicals together and puts them through a mixing machine followed by a drying hopper. Petitioner also explained that he would lift materials weighing 50-60 lbs., including bags of dry chemicals or drums containing products.

On cross examination, Petitioner testified that at one point he owned a business for 5-7 years. Petitioner testified that he was primarily the owner, but he did do work including drywall, flooring and basic residential repair with the exception of roofing he did not do much. Petitioner testified that he had a lot of subcontractor do this work. He stopped working this business in early 2012.

Petitioner testified that on the date of accident his machine gave an error reading and he went to the second floor to see what the problem was. On his way to the hopper, Petitioner testified that there was a sealed copper drum in his path. He stopped to toss the fiber drum out of the way and did not realize it was filled with a wet powder. Petitioner explained that he bent over and wrapped his arm around the drum and went to twist and toss it out of the way. As he went to toss the drum, Petitioner testified that he felt a pop in his back and went down to his knees.

On cross examination, Petitioner testified that he had an assistant at the time of the injury, Jimmy. He explained that it varied whether he would operate the forklift or his assistant would do that. Petitioner explained that the milling cylinder responsibilities were shared. In order to do repair work, Petitioner would have to remove doors weighing 25-30 pounds, augers that weighed 25/30/40 pounds and use the fork truck to move chemicals. Prior to the incident at work, Petitioner testified that he did not do much lifting on the milling cylinder machine.

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[1] Respondent disputes that Petitioner is entitled to temporary total disability benefits after March 1, 2014 when he was released to full duty work by Dr. Moody. AX1.

[2] The Arbitrator similarly references the parties' exhibits herein. Petitioner's exhibits are denominated "PX" and Respondent's exhibits are denominated "RX" with a corresponding number as identified by each party. Exhibits attached to depositions will be further denominated with "(Dep. Exh. _)."

Petitioner also testified that he would lift fiber drums weighing 50-60 pounds. When Petitioner returned to work in March and April, he had a helper. Petitioner testified that the helper would he do 15-20% of lifting and Petitioner would do about 80% of lifting. Petitioner testified that he never had to do this however and that 80% of the time he was able to lift 50-60 pounds himself.

Medical Treatment

Petitioner was then taken by Mr. Copeland to seek medical care at St. Francis Hospital in Peoria. Petitioner testified that he reported back and butt pain.

The medical records reflect that Petitioner presented to OSF St. Francis Medical Center on January 23, 2014 reporting back pain that began at 8:30 p.m. that evening while "moving a 55 gallon drum when he twisted and felt as if someone hit him 'in the back with a bat.'" PX5. He also reported neck pain and pain radiating to his abdomen, but denied radiating pain into the lower extremities. *Id.* Petitioner underwent lumbar and thoracic x-rays that showed no acute abnormality. *Id.* The emergency room physician offered diagnosed Petitioner with back pain and discharged him from care with a prescription for pain medications. *Id.* Petitioner was kept off work that night and restricted from heavy lifting, pushing or pulling until he was cleared by an occupational health doctor. *Id.*

Petitioner testified that he then saw Dr. Moody reporting back pain as though he was hit and a sharp shooting pain in his butt cheeks. The medical records reflect that on January 27, 2014, Petitioner saw Edward B. Moody, M.D. ("Dr. Moody") at OSF St. Francis Center for Occupational Health. PX4, PX5. Petitioner reported a consistent mechanism of injury and an onset of pain mainly in the middle of his back radiating down to the gluteal region. *Id.* He also reported worsened symptoms with motion, especially twisting, and inability to sit over 30 minutes. *Id.* After an examination, Dr. Moody diagnosed Petitioner with a lumbar strain with some pretty significant impairment in motion. *Id.* He ordered physical therapy and imposed work restrictions with no lifting over 10 pounds, no bending or twisting, sitting and standing as needed, and a four-hour workday. *Id.*

Petitioner began physical therapy at OSF St. Francis Medical Center and returned to Dr. Moody on January 30, 2014 and February 6, 2014. PX4, PX5. Petitioner's work restrictions were lessened and Petitioner was released to work six hours per day with rare lifting over 15 pounds, bending and twisting. *Id.* His work restrictions were modified again at a follow up with Dr. Moody on February 18, 2014. *Id.* Petitioner continued physical therapy and was discharged on February 25, 2014. *Id.*

The following day on February 26, 2014 Petitioner returned to Dr. Moody. PX4, PX5. He reported that he resumed normal activities of daily life, he did get occasional muscle spasms at night, but was doing well during the day, and he was able to lift 50 pounds in physical therapy the day before without significant difficulty. *Id.* Dr. Moody indicated that Petitioner had significantly improved. *Id.* He discontinued physical therapy and released Petitioner back to full duty work effective March 1, 2014. *Id.*

Petitioner testified that he returned to work as an operator and he continued to do his job. However, he explained that the job changed in that the chemical he manufactured prior to his injury was removed by forklift while the new product he was extracted into fiber drums and taken manually to be placed on pallets. Petitioner testified that when he was initially released to return to work, he continued to have spasms which he reported to Dr. Moody and the physical therapist. After his release to return to work, Petitioner testified that his spasms did not end, they only increased. Petitioner testified that he did not seek medical treatment with his family doctor at

that time.

On cross examination, Petitioner testified that after his return to work he worked a new product on the same machine, but he continued to work full duty. He acknowledged that he had no medical treatment from March 1, 2014 through May 7, 2014. Petitioner also reported that his pain was really bad and that he left a detailed message with Jeff Hampton ("Mr. Hampton").

E-mail, Voicemails & Testimony of Jennifer Hirsch

Respondent called Ms. Hirsch as a witness. She testified that she is currently employed as the Warehouse and Materials Manager and has been so employed for three months. Previously she was the Operations Manager for about 2 ½ years. Mr. Hirsch explained that she was responsible for about 60 employees in this position and that she was Petitioner's direct supervisor. Ms. Hirsch testified that she is familiar with Petitioner's duties and that Petitioner would be directing a helper on his machine process.

Ms. Hirsch testified that Petitioner's job responsibilities on the DFP (a dry herbicide process) process would be to run and monitor the computer process that was automated and the helper was performing the manual work. Ms. Hirsch testified that all processes were automated and that there was only one line with raw materials weighing 25 pounds transported via fork truck in a metal tote.

Petitioner testified that Petitioner's light duty was accommodated and he returned to work on March 1, 2014. In March and April of 2014, Ms. Hirsch testified that Petitioner's machine ran a product called SLZ/CHLOR for seven weeks and on the eighth week they ran the exclusion product. In April of 2014, with regard to the exclusion product, Ms. Hirsch testified that the line lead and helper would lift the 25 pound bag, hold it up against the equipment, slice it open and pour it into the machine. She explained that there is a fiber drum on a roller conveyor and that they would "rim roll" it onto a pallet onto the same level. Ms. Hirsch testified that these employees should not be physically lifting the drum and that she has never seen anyone physically lift the fiber drum.

Ms. Hirsch testified that she was Petitioner's supervisor in March and April of 2014 because she scheduled his daily shift and communicated with a senior operator on her shift. Ms. Hirsch was also present twice per week at the beginning or end of Petitioner's shift for an hour. Ms. Hirsch was accountable for the weekly process and knew who was working on what days and shifts. Ms. Hirsch testified that if an employee was injured and needed a restriction up to 50 lbs. there was an available accommodation.

Ms. Hirsch testified that she knew Petitioner's schedule when he returned to work and that the last date that Petitioner worked for Respondent was April 30, 2014. Petitioner was not scheduled to work May 1 through 3, 2014, but he was scheduled for May 4, 2014. Ms. Hirsch testified that Petitioner called in to work about a water line break in his front line. Petitioner was also scheduled to come in on May 5, 2014, but he could not come in due to back pain. Ms. Hirsch testified that Petitioner never returned to work for Respondent.

Respondent offered into evidence an email from Mr. Hampton regarding Petitioner to Jennifer Hirsch ("Ms. Hirsch") and two others. RX2. The email reflects that Ms. Hirsch requested that Mr. Hampton "provide written documentation regarding the voicemails Brian Cox left on [his] phone last week[,]" as well as "any description of conversations [Petitioner] had with [him] regarding his absences related to the main water break earlier in the week." *Id.* Ms. Hirsch explained that Betty Hartwell was Respondent's Human Resources person and the other email recipient left Respondent's employment in August of 2015.

The email reflects the following, in pertinent part:

> This is a word for word dialog from the voicemails I received from Brian Cox. I would like to note that the phone number he called from showed up as unknown so I was unable to return any of his calls. I would also like to mention that at no time since Brian's return has he made any mention of aggravating any previously reported injury nor has he brought any new injury to my attention.
>
> Sunday May 4th 5:13 P.M.
>
> Hey it's Brian, give me a [expletive] call back as soon as you can. I'm not going to be in there my [expletive] water line just busted in my front yard. Call me back or something.
>
> Monday May 5th 5:12 P.M.
>
> Hey [expletive] give me a call back. It's Brian, not sure when I'll be in there. *Gotta go to the doctor tomorrow and get a brace put on, see when they'll release me to work.* Give me a call.
>
> Tuesday May 6th- No call No show
>
> Wednesday May 7th 5:32 P.M.
>
> *Ya, I was letting you know I'm not released to go anywhere until the 12th pending the results of the Orthopedic specialist.* Give me a call.

RX2 (*emphasis* added).

On cross examination, Ms. Hirsch testified that she typically worked the first shift, but Petitioner returned on the day shift for five weeks and then went back. Ms. Hirsch acknowledged that she was typically not on the night shift.

Regarding the fiber drums, Mr. Hirsch explained that these are filled by employees who operate a valve that fills the drums to 60 pounds. The drums are moved on rollers and placed on a pallet and "rim roll." She explained that these fiber drums are the only ones on "DFP," Petitioner's process.

Ms. Hirsch had no dispute as to the reported mechanism of injury by Petitioner in January involving the 55-gallon drum. She also testified that there was no investigation regarding the materials identified in the voicemail, any investigation regarding the calls, and Ms. Hirsch testified that she was not told who complained or how.

May 7, 2014

On re-direct examination, Petitioner testified that when the waterline busted he called his landlord and explained that he did not repair it himself. Petitioner testified that he was getting up to $900 water bills. He explained that he did not know if he needed to be home to repair the waterline so he called in to work. He maintained on further cross examination that his landlord fixed the waterline and that he did not assist in that task. Petitioner also testified that he woke up with throbbing back pain that started moving past the butt into his legs, which prompted his visit to the emergency room on May 7, 2014.

On May 7, 2014, Petitioner testified that he went to the emergency room at St. Luke Medical Center. He testified that the pain was really bad and that his back was throbbing with pain moving past his butt into his left cheek. Petitioner testified that his pain did not subside at any time after his accident at work.

The St. Luke Medical Center records reflect that Petitioner reported an onset of back pain that began the previous night with pain radiating into the left leg. PX6. The emergency room nurse noted "Patient states: he hurt his back in January and has not had problems with it until last night it started feeling tight and today the pain is very bad and limiting his ability to move." *Id.* The records also reflect Petitioner's report that the onset of his low back pain occurred last night and that the "problem was sustained when bending over, when lifting." *Id.* Petitioner was diagnosed with acute low back pain and leg pain, instructed to follow up with the clinic within a week and was discharged home. *Id.*

Petitioner then followed up with Dr. Michael Ahearn ("Dr. Ahearn") on May 9, 2014. PX7. Petitioner testified that he continued to have back pain and a prickly feeling in his left upper leg at this time. Dr. Ahearn's records reflect Petitioner's report of muscle weakness and back pain. *Id.* Dr. Ahearn diagnosed Petitioner with low back pain "worse non radicular cant drive any more to Peoria intermitant (sic) paresthesias i (sic) thigh obturator[.]" *Id.* He ordered a lumbar MRI and physical therapy. *Id.*

Petitioner then underwent physical therapy at Stark County Physical Therapy. PX8. Petitioner testified that in physical therapy he did various bending and stretching exercises that did not help him. The Stark County Physical Therapy records reflect that Petitioner was discharged on May 13, 2014 "due to poor compliance with scheduled visits." *Id.*

On May 14, 2014, Petitioner underwent the recommended lumbar MRI at St. Luke Medical Center. PX6. The interpreting radiologist noted the following: (1) diffuse bulging desiccated discs at L4-L5 and L5-S1; (2) no evidence of focal disc herniation or lateralizing findings; (3) degenerative changes in the facets at L4-L5; and (4) an otherwise unremarkable examination. *Id.*

Petitioner returned to Dr. Ahearn on May 20, 2014 reporting, in pertinent part, "back pain (since January had injury LS sprain after grabbed to lift a barrel full of wet product >200 lbs and he felt back pain. he did PT for a month with little relief. returned to work light duty for a month and then to full duty. pain persists and radiates into the left leg down to the knee. some numbness occasionally in the left anterior thigh)...." Dr. Ahearn diagnosed Petitioner with radicular pain and a prolapsed lumbar intervertebral disc. *Id.* He noted the results of Petitioner's MRI showing desiccated diffusely bulging discs with continued pain in the back radiating to the left leg with no results from four months of physical therapy. *Id.* Dr. Ahearn referred Petitioner for a neurosurgical consultation. *Id.*

The medical records reflect that Petitioner was then referred to Richard A. Kube, M.D. ("Dr. Kube"). PX3. Petitioner first saw Dr. Kube on May 29, 2014 who noted the following history:

> The patient is here today as a referral from Dr. Mike Ahearn in Kewanee. He is here with complaints of pain going on since an injury occurred at work in January 2014. He indicates that he was trying to move a barrel at work. Typically, these barrels contain about 65 pounds worth of product, but there was a different type of wet powder or something in the barrel on that occasion – there was over 200 pounds of product. He went to lift and it was much heavier than expected, and he felt something go down into his back. He had severe back pain almost immediately and spasm that has continued. More recently, in May, he has had leg pain start up on the left side, and this is bothering him more consistently now than it was in the past. The pain, in general, is better, but he is still having quite a bit of spasm despite the

therapy he is having. At this point, he wants to know what else we might recommend for him.

Id. Dr. Kube reviewed Petitioner's x-rays which he noted showed very minimal loss of disc height at L4-L5 and L5-S1, no significant spur formation, and no spondylolysis or spondylolisthesis. *Id.* He also reviewed Petitioner's MRI, which he noted to show moderate degenerative change at L4-L5 and L5-S1 with annular tears at both levels. *Id.* Dr. Kube diagnosed Petitioner with sacroiliac joint pain, lumbar stenosis and degenerative change likely aggravated by his accident at work. *Id.* He recommended epidural steroid injections. *Id.*

On June 16, 2014, Petitioner underwent transforaminal lumbar epidural steroid injections at L4-L5 and L5-S1. PX3. Petitioner testified that the injections provided no relief. *Id.*

On August 17, 2014, Petitioner went to UnityPoint Health Peoria Methodist reporting left ankle pain over three weeks with no injury. PX9. On examination, Petitioner had diffuse nonlocalized tenderness of the ankle with swelling and increased skin warmth. *Id.* Petitioner was diagnosed with gout. *Id.*

As recommended by Dr. Kube Petitioner then underwent a discogram performed by Dr. Kube on September 8, 2014. PX3. He diagnosed Petitioner with degenerative disc disease and back pain with annular tearing from L4-S1. *Id.* The discogram was negative at all three levels. *Id.* The following day on September 9, 2014, Petitioner returned to Dr. Kube who noted that the discogram was negative. *Id.* He also noted that a trial cord stimulator may be appropriate. *Id.* Dr. Kube ordered a functional capacity evaluation and restricted Petitioner to sedentary work. *Id.*

Then on September 11, 2014, Petitioner returned for emergency care at UnityPoint Health Peoria Methodist. PX9. The evaluating physician noted a history including "[b]ack injury 1-2 years ago; now has L4/L5 & L5/S1 disc disease by MRI - underwent discogram few days ago and pain is getting worse. Has intermittent numbness medial L foot and parasthesias (sic) to same. Today tried to get up and L leg gave way - too weak; almost fell." *Id.* Petitioner was diagnosed with left-sided sciatica, lumbar disc disease with radiculopathy, and obesity. *Id.*

Petitioner followed up with his primary care physician on September 18, 2014. PX7. He reported his emergency room visit and "*c/o severe back pain, and leg weakness, symptoms started after having a discogram with Dr Kube on 9/8/14 Patient reports symptoms have worsened since having that done.* Wants referral to someone else[.]" *Id.*, (*emphasis* added). Dr. Ahearn diagnosed Petitioner with a prolapsed lumbar intervertebral disc and bilateral radicular pain. *Id.*

On October 9, 2014, Dr. Kube noted that the recommended functional capacity evaluation had not been authorized and again suggested a trial cord stimulator. PX3.

October 28, 2014 Narrative Report – Dr. Kube

On October 28, 2014, Dr. Kube authored a narrative report at Petitioner's counsel's request. PX3. He diagnosed Petitioner with chronic back and leg pain secondary to trauma which he believed aggravated Petitioner's degenerative condition. *Id.* Dr. Kube also diagnosed Petitioner with annular tears and radicular components to his pain. *Id.* Dr. Kube noted that Petitioner's dermatomal-type pain had been relatively consistently associated with the left-side at L5-S1 and right-side at S1 as well as bilateral sacroiliac joint pain greater on the left and some mid low back pain. *Id.* He also noted that Petitioner's MRI showed annular tears at L4-L5 and L5-S1 with some lateral recess stenosis and disk protrusions. *Id.* Dr. Kube acknowledged that there was a specific sensory deficit, but no specific motor deficit. *Id.*

Dr. Kube made three recommendations. *Id.* He indicated that surgery was not likely appropriate, but he did recommend an EMG/NCV to assess the radiculopathy and possibly followed by a decompression surgery although it was unlikely to address Petitioner's back pain. *Id.* Dr. Kube also noted that Petitioner had no substantial motor weakness and he characterized Petitioner's stenosis as mild. *Id.* However, he also recommended a dorsal column stimulator trial followed by a permanent implant if appropriate to address Petitioner's back pain. *Id.* Finally, Dr. Kube recommended a functional capacity evaluation to evaluate Petitioner's condition. *Id.*

Ultimately, Dr. Kube opined that Petitioner's low back and leg condition was causally related to his injury at work based on the history given to him and as reflected in the medical records he reviewed, Petitioner's onset of symptoms, and the mechanism of injury. *Id.*

Continued Medical Treatment

As of November 20, 2014, Petitioner reported bilateral leg symptoms with weakness such that his legs shake violently when he reaches the top of a flight of stairs. PX3. Dr. Kube noted that Petitioner was under the care of his primary care physician for pain medication management at that time and he kept Petitioner restricted to sedentary work. *Id.* As of January 20, 2015, Petitioner's functional capacity evaluation had yet to be approved. *Id.*

Section 12 Examination – Dr. VanFleet

On December 23, 2014, Petitioner saw Timothy VanFleet, M.D. ("Dr. VanFleet") at Respondent's request. RX1 (Dep. Exh. 2). Dr. VanFleet's report reflects that he took a history from Petitioner, examined him, reviewed various treating medical records, and rendered opinions regarding his physical condition. *Id.*

Dr. VanFleet diagnosed Petitioner with low back pain, obesity and multilevel disc disease. *Id.* He indicated that Petitioner's back pain coincided with his injury at work and that he had gradual improvement in his condition until his release from care and a recurrence of symptoms consistent with lumbar degenerative disc disease. *Id.* However, Dr. VanFleet did not recommend surgery or a spinal cord stimulator. *Id.* He noted that Petitioner was at maximum medical improvement and that additional studies and testing after the injections with Dr. Kube would not have changed the outcome in Petitioner's condition. *Id.* Dr. VanFleet recommended a functional capacity evaluation and opined that Petitioner "was released back to work without restrictions. He had a recurrent onset of pain across his back which was not necessarily related to any specific work injury. Therefore, I do not feel that any work restrictions would be related to his work injury in January of 2014." *Id.*

Continued Medical Treatment

Petitioner ultimately underwent the functional capacity evaluation on August 17, 2015. PX12. The results of the functional capacity evaluation were deemed valid by the evaluating physical therapist and Petitioner was released at the medium physical demand level. *Id.*

Deposition Testimony – Dr. Kube

Petitioner called Dr. Kube as a witness and he provided testimony at an evidence deposition on August 21, 2015. PX11. Dr. Kube testified that he is a board certified spine surgeon, orthopedic surgeon, and independent

medical examiner. PX11 at 4-8; PX11 (Dep. Exh. 1). He also holds himself out to be an expert in medical billing. *Id.*, at 51-54. Dr. Kube testified consistent with the information contained in his narrative report and medical records. *See generally* PX11. He also explained his opinions. *Id.*

Dr. Kube explained what he saw in Petitioner's MRI in detail. PX11 at 12-17. He explained that while Petitioner did not have a big herniation or typical mass effect in the spine, his MRI did show contact on the nerve root at L5-S1 and he noted a "snug region" or stenotic area around L5-S1 and "the same path of physiology exists there as it does at L4-5." *Id.*, at 17.

Dr. Kube also testified that based on Petitioner's complaints to him and his physical examination of Petitioner, he found Petitioner's "sensory deficits would probably be the objective components there." PX11 at 17. He also testified that Petitioner's complaints were consistent with his findings in Petitioner's MRI. *Id.*, at 17-18. Dr. Kube noted that Petitioner's discogram of September 8, 2014 was negative, but he testified that it did not mean that Petitioner was not having pain; rather there were limited surgical interventions available to help Petitioner. *Id.*, at 27-29. He also noted that Petitioner had a near full thickness annular tear at L4-L5 and a full thickness tear at L5-S1. *Id.*, at 29.

Dr. Kube maintained that Petitioner's condition in the spine was associated to his accident as follows:

> Well, I think it would be -- I think that there's an association. To a degree of medical and surgical certainly, I would say it's probably an aggravation. I don't think -- you know, there's really not a way that I could say for certain that this annular tear happened at that time. You know, an MRI is one snapshot in time, so I really don't -- I can't really make a before and after comment. But some of the arthritic change certainly probably predated the time of the injury, but, you know, per history, the symptoms did not. And so, therefore, I would have to opine, based upon the history that he provided me, that this -- this region of this spine that these findings [at L4-5, L5-S1] were aggravated by the lifting maneuver that he described.

Id., at 19-20. After reviewing his narrative report, Dr. Kube later testified:

> I believe at the time of the lifting maneuver that he described he aggravated his back and lumbar spine, and given the contemporaneous onset of symptoms, the mechanism that he described, it fits a common mechanism of injury for folks with lumbar spines.

Id., at 37-38.

Dr. Kube testified that Petitioner did not describe any intervening events of trauma or accident to him. PX11 at 10. He also recommended a trial dorsal column stimulator followed by a permanent stimulator if the trial was successful, otherwise indefinite medication management. *Id.*, at 37. After reviewing Petitioner's functional capacity evaluation results, Dr. Kube indicated that he would still recommend a stimulator and he placed him on a permanent work restriction consistent with 50 pounds occasional lifting at the medium physical demand level. *Id.*, at 45.

On cross examination, Dr. Kube testified that he relied on the findings in Petitioner's MRI as well as the history provided by Petitioner in reaching his opinion that the accident at work aggravated Petitioner's condition. PX11 at 58-60. Regarding Petitioner's leg pain, Dr. Kube testified that Petitioner was not the typical patient presenting with a large herniated disc. *Id.*, at 60-61. He explained:

> You know, we really honestly don't know exactly what the mechanism is, but we know what kinds of things are in the disc and, you know, if those types of things just happen to leak out right, you know, then maybe chemically irritates it, but beyond that I don't know. That's why a lot of times we'll see with an annular tear that the tear can be on the right but the symptoms are on the left. So the symptoms for the leg stuff aren't real consistently reliable all the time with an annular tear. So that's, you know, of course also why I wouldn't recommend just doing a decompression on this guy because I don't think it will change that.

Id.

Also on cross examination, Dr. Kube testified about an article from VIP Medical Consulting and Scott Becker, an attorney with McGuire Woods, titled "10 Ways to Improve Profitability for Pain Management" in which he was quoted. PX11 at 72-83. Dr. Kube testified essentially that profitability as a specialist increased when patients received comprehensive care. *Id.* That is, primary care physicians would refer more patients to him as a specialist if he provided comprehensive care than if he did not so he did not "squeeze" $10,000 out of one patient a year but received 100 patient referrals for $1,000 per year. *Id.*

Deposition Testimony – Dr. VanFleet

Respondent called Dr. VanFleet as a witness and he provided testimony at an evidence deposition on August 26, 2015. RX1. Dr. VanFleet testified that he is a board certified orthopedic surgeon. RX1 at 5-9; RX1 (Dep. Exh. 1). Dr. VanFleet testified consistent with the information contained in his Section 12 report. *See generally* RX1. He also explained his opinions. *Id.*

Dr. VanFleet opined that Petitioner did sustain an injury at work resulting in a back strain, which resolved by March 1, 2014. RX1 at 12-13. He noted that Petitioner was released back to full duty work and was able to function in that capacity for some time. *Id.*, at 24. Dr. VanFleet also testified about the records that he reviewed relating to Petitioner's medical care before and after May 7, 2014 when he visiting the emergency room. *Id.*, at 16-17. He explained that Petitioner was describing some shooting or stabbing type sensations into the legs, more on the left. *Id.* When asked about Petitioner's pain complaints beginning in May after he believed Petitioner had reached maximum medical improvement, Dr. VanFleet explained that Petitioner had an underlying condition of degenerative disc disease and obesity, which were two prevalent causes for chronic nonspecific low back pain. *Id.*, at 23-24.

Dr. VanFleet testified that he does not personally perform discograms, but that he will occasionally order them. RX1 at 7. He explained that it is better to have someone else perform a discogram so that there is no bias and the study is blind. *Id.*, at 7-8. He also explained that one looks for concordance or pain reproduction where the disc spaces are injected to determine if the patient's pain is coming from any of those disc spaces. *Id.*, at 18-19. With regard to Petitioner's discogram results, Dr. VanFleet testified that since the results were negative "one would safely assume that the pain is not coming from any of those disc spaces." *Id.* Dr. VanFleet also testified that he would not typically entertain a discogram until six months of nonoperative intervention, and Petitioner's occurred approximately four months after the May 2014 onset of pain so he would not deem the discogram to have been an appropriate measure. *Id.* at 19, 41-42. On cross examination, Dr. VanFleet testified that a discogram is not performed to identify radicular type pain. *Id.*, at 38. However, he maintained that while discogram results are not 100%, if the disc is the source of pain a properly conducted discogram should reproduce pain at the disc space. *Id.*, at 38-39.

Dr. VanFleet also testified about dorsal column stimulators. RX1 at 20-21. He explained that it works best for individuals that have lower extremity pain and that it does not work very well for patients with axial back pain. *Id.* With regard to Petitioner, Dr. VanFleet testified that Petitioner's complaints were primarily of back pain with nonspecific lower extremity pain "unsubstantiated by any form of imagine study. So there was no correlative imaging studies that would suggest that this gentleman had any kind of compressive radiculopathy or neuropathy taking place in his lumbar spine." *Id.* at 21. Dr. VanFleet opined that a dorsal column stimulator was not reasonable or necessary for Petitioner because it would not offer his any help with respect to his predominant complaint of back pain. *Id.*, at 22.

On cross examination, Dr. VanFleet acknowledged that Petitioner had no prior complaints of back pain or trauma before his accident at work. RX1 at 25. He acknowledged that the trauma sustained at work was competent to cause the type of symptoms of thoracic and axial low back pain reported by Petitioner thereafter, and that the type of trauma sustained by Petitioner was competent to aggravate degenerative disc disease. *Id.*, at 25-26, 30.

On cross examination, Dr. VanFleet also acknowledged that he did not review Petitioner's MRI and x-ray films, only the reports. RX1 at 28. He conceded that Petitioner's report to Dr. Ahearn on May 9, 2014 of leg pain since finishing physical therapy in February would be consistent with complaints of ongoing back and leg pain since his injury. *Id.* at 35-36. Dr. VanFleet also conceded that while Petitioner had desiccated discs from L4-S1 that were evident in his MRI and pre-existed his accident at work, this degenerative condition could have been aggravated by the type of trauma described by Petitioner as occurring at work. *Id.*, at 37.

With regard to the appropriateness of the epidural steroid injections performed by Dr. Kube, Dr. VanFleet testified that such injections are appropriate "if there are correlative imagine studies, and one is believe to be having a lumbar radiculopathy, then an epidural steroid injection would be an appropriate treatment." RX1 at 41.

On re-direct examination, Dr. VanFleet testified that there was no correlation between Petitioner's studies and his pain complaints. RX1 at 52-53. He explained that there was relative nonspecificity and nondermatomal radiation of pain into Petitioner's leg that would be consistent with radiculopathy and "when you have this nonspecific, vague complaints of burning, shooting pain all over the legs, and you look at the MRI, and there's nothing that's consistent with that, in my mine there's no reason to progress to an epidural steroid injection, and, in fact, he did have one done, but it didn't help." *Id.*

Dr. VanFleet also clarified his opinion regarding causal connection. RX1 at 54. He explained that who Petitioner had a strain initially, his symptoms improved and he was released back to work without restriction. *Id.*

Additional Information

Since May 7, 2014, Petitioner testified that no physician has released him to return to work. He explained that while under the care of Dr. Kube, he was prescribed prescriptions to help him with lower back and leg pain. Petitioner was also prescribed Ambien for sleep medication, but he was unable to take that. Petitioner testified that he had hallucinations and a constant blurred slow motion feeling. *See also* PX3. Petitioner testified that Dr. Kube continues to have him off work.

Regarding his current condition, Petitioner testified that he has limited current activities. He has to carry

groceries and he is a father, but he explained that he mostly sits in his chair at home. Regarding his back, Petitioner testified that he has frequent spasms and aching and pain in his tailbone. He also has pain shooting down his legs and experiences weakness and numbness when going down stairs. Petitioner also testified that he has difficulty sleeping and he has spasms that wake him up every 2-3 hours. He explained that he now sleeps in a recliner because it is the most comfortable and easiest to get out of in the morning. Petitioner also testified that he has numbness is in his feet, generally going down his right leg worse than the left.

Petitioner testified that he has three children that are 8, 18 months and 6 months. He testified that he picks up his children if he has to do so. He also carries groceries and has done some yard work and weeded it some time ago. Petitioner testified that his fiancé normally does the yard work. He also testified about installing a new furnace into a home purchased at auction with his father-in-law in 2015 and driving to and from Ft. Myers, Florida with his children for his brother's wedding. Petitioner testified that he was there 2 ½ days.

Petitioner testified that he can comfortably sit or stand for about 30 minutes. He also testified that he currently takes over-the-counter medications everyday every couple of hours. Petitioner also testified that he takes 3-4 ibuprofen or aspirins three times per day. Petitioner testified that he drove here today about 2 hours and 15 minutes, and he noticed numbness and tingling in his legs and that his back throbs. Since May 7, 2014, Petitioner testified that he has not been employed.

ISSUES AND CONCLUSIONS

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

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

The Arbitrator finds that Petitioner's current condition of ill-being in the lumbar spine is causally related to his injury at work to the extent opined by Dr. VanFleet through March 1, 2014. In so concluding, the Arbitrator finds Petitioner's testimony not to be credible and further finds the opinions of Dr. VanFleet to be persuasive.

There is no dispute that Petitioner was asymptomatic in the low back before his accident at work. He was a young man of 32 years of age at that time and he had continuously worked in his full duty position for Respondent for some time before his injury. It is also clear that Petitioner only complained of back pain after his accident at work and some generalized complaints of pain in the leg or legs. The parties' dispute regarding causal connection centers essentially on Petitioner's credibility; that is, whether Petitioner sustained an intervening accident at home that caused Petitioner to seek emergency medical treatment on May 7, 2014. Before addressing Petitioner's credibility, however, a review of the medical opinions and evidence is pertinent.

"Liability cannot be premised upon imagination, speculation or conjecture but must arise from facts established by a preponderance of the evidence." *Illinois Bell Tel. Co. v. Industrial Comm'n*, 265 Ill. App. 3d 681, 685 (1st Dist. 1994). "Expert opinions must be supported by facts and are only as valid as the facts underlying them." *Gross v. Ill. Workers' Comp. Comm'n*, 2011 IL App (4th) 100615WC, *16-17, 960 N.E.2d 587, 594 (4th Dist. 2011) (*citing In re Joseph S.*, 339 Ill. App. 3d 599, 607 (1st Dist. 2003)).

Both Petitioner's treating orthopedic surgeon, Dr. Kube, and Respondent's Section 12 examiner, Dr. VanFleet, agree that Petitioner's post-accident radiographic studies show minimal degeneration in the lumbar spine. Dr. Kube conceded that there was no disc herniation showing in Petitioner's MRI, but he maintained that Petitioner's desiccation, mild stenosis and annular tears were the source of Petitioner's pain complaints. However, the discogram that he personally performed showed no correlation of pain when provoked at any level during the diagnostic exam. Dr. Kube nonetheless recommends a spinal cord stimulator as Petitioner's method of treatment, but conceded that a spinal cord stimulator was unlikely to address Petitioner's low back pain.

Dr. Kube's opinion that Petitioner's ongoing complaints of low back pain are causally related to the trauma sustained at work might be persuasive in this case given Petitioner's young age, lack of prior symptoms, and continued complaints (even if sometimes vague) after his accident at work were it not for Petitioner's lack of credibility and the complete lack of objective medical evidence to corroborate Petitioner's complaints. Indeed, Dr. Kube based his opinion and recommendation for a spinal cord stimulator in large part on Petitioner's account of events and subjectively reported symptoms. Petitioner's subjective reports, however, are controverted by Dr. Kube's own review of Petitioner's MRI and negative discogram findings. Dr. Kube's triple board certification and own opinion that he is a medical billing expert, in this case, only undermines his opinions and recommendations for treatment in light of the foregoing. The opinions of Dr. Kube are simply not persuasive given the entirety of the evidence in this case.

Dr. VanFleet initially examined Petitioner at Respondent's request and agreed that Petitioner sustained an injury

to his low back at work. At his deposition, he repeatedly conceded that the type of trauma Petitioner sustained at work could result in an aggravation of his degenerative lumbar condition. He understood that Petitioner had no prior low back condition or treatment and he knew of no intervening accident. However, Dr. VanFleet based his opinion that Petitioner reached maximum medical improvement on Petitioner's ability to work full duty for two months after March 1, 2014 and the lack of objective evidence in his MRI or x-rays showing a disc herniation or other condition competent to cause Petitioner's complaints low back and diffuse leg complaints after May 7, 2014. Dr. VanFleet's opinions are persuasive in this case because neither he nor Dr. Kube (although he might disagree) were able to identify an objective source of Petitioner's reported pain complaints via x-rays, an MRI, a discogram or physical examinations. Moreover, Dr. VanFleet's opinions are persuasive because Petitioner was able to work full duty for two months before allegedly sustaining a spontaneous onset of pain, which is controverted by Petitioner's reports at the emergency room on May 7, 2014. Petitioner's testimony about the events leading up to and occurring on May 7, 2014, in particular, lacks credibility.

"Every natural consequence that flows from an injury that arose out of and in the course of one's employment is compensable under the Act absent the occurrence of an independent intervening accident that breaks the chain of causation between the work-related injury and an ensuing disability or injury." *Nat'l Freight Indus. v. Ill. Workers' Comp. Comm'n*, 2013 IL App (5th) 120043WC *26 (citing *Vogel v. Industrial Comm'n*, 354 Ill. App. 3d 780, 786 (2nd Dist. 2005); *Teska v. Industrial Comm'n*, 266 Ill. App. 3d 740, 742 (1st Dist. 1994)). However, "[u]nder an independent intervening cause analysis, compensability for an ultimate injury or disability is based upon a finding that the employee's condition was caused by an event that would not have occurred 'but for' the original injury." *Nat'l Freight Indus.*, 2013 IL App (5th) 120043WC *26 (citing *International Harvester Co. v. Industrial Comm'n*, 46 Ill. 2d 238, 245, 263 N.E.2d 49 (1970)).

The Arbitrator does not find Petitioner's testimony to be credible when viewing his testimony at trial in light of the medical records and other evidence proffered. In so concluding, Petitioner's testimony about the waterline break, the email documenting Petitioner's voicemails to his supervisor and Petitioner's reports to emergency room personnel on May 7, 2014 are informative.

At trial, Petitioner testified that he did not know if he needed to be home to repair the waterline so he called in to work and left a message for Mr. Hampton. The email Ms. Hirsch received from Mr. Hampton regarding Petitioner's voicemails, however, tells a different story. While Petitioner did leave a voicemail for Mr. Hampton on Sunday, May 4, 2014 at 5:13 p.m. explaining that his waterline broke, and Petitioner's testimony that he did not help his landlord fix the waterline is uncontroverted, it is Petitioner's voicemail the following day on Monday, May 5, 2014 at 5:12 p.m. that raises concern about his credibility.

In his voicemail, Petitioner stated "... It's Brian, not sure when I'll be in there. *Gotta go to the doctor tomorrow and get a brace put on, see when they'll release me to work.* Give me a call." RX2 (*emphasis* added). However, Petitioner had no pending appointment with any physician at that time and there is no indication that he had been placed off work and needed to be released back to work. Indeed, Petitioner testified on cross examination that he saw no doctor and received no medical treatment after March 1, 2014 until May 7, 2014. Petitioner did not report to work the following day on May 6, 2014. Then on May 7, 2014 he left another voicemail indicating that he was "not released to go anywhere until the 12th pending the results of the Orthopedic specialist." *Id.*

Moreover, Petitioner's credibility about having assisted in the repair of his waterline at home is undermined by the emergency room medical records. These records reflect that Petitioner reported an onset of back pain that began the previous night (on May 6, 2014) with pain radiating into the left leg with onset of his low back pain

"was sustained when bending over, when lifting." PX6. The emergency room nurse noted Petitioner's report that he was injured back in January, but he had no "problems with it until last night it started feeling tight and today the pain is very bad and limiting his ability to move." *Id.* Petitioner's testimony at trial that he woke up with throbbing back pain that started moving past the butt into his legs is controverted by his report at the emergency room that his pain began while bending over and lifting and not spontaneously in the middle of the night while sleeping. Petitioner's waterline broke on May 4, 2014 and it appears that Petitioner knew as of May 5, 2014 that he was going to the doctor to get a brace and to "see" when they would release him to work despite the fact that he testified that he had not seen any doctor and no medical record shows that he was off work at this time. As noted by Mr. Hampton in his email to Ms. Hirsch, Petitioner did not report any injury to him at any time after January.

Given the totality of the medical evidence in this record, the Arbitrator finds the opinions of Dr. VanFleet to be persuasive and adopts those opinions herein. Dr. VanFleet's opinions are further supported by the findings of Petitioner's own treating physician, Dr. Kube, who found no evidence of concordant pain in the lumbar spine during the discogram that he personally performed and who conceded that a spinal cord stimulator was unlikely to address Petitioner's reported low back pain. Moreover, Dr. VanFleet's opinions are persuasive given Petitioner's lack of credibility regarding the events immediately preceding his visit to the emergency room on May 7, 2014.

Based on all of the foregoing, the Arbitrator finds that Petitioner's current condition of ill-being in the lumbar spine is causally related to his injury at work as opined by Dr. VanFleet through March 1, 2014.

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

"Under section 8(a) of the Act (820 ILCS 305/8(a) (West 2006)), a claimant is entitled to recover reasonable medical expenses, the incurrence of which are causally related to an accident arising out of and in the scope of her employment and which are necessary to diagnose, relieve, or cure the effects of the claimant's injury." *Absolute Cleaning/SVMBL v. Ill. Workers' Compensation Comm'n*, 409 Ill. App. 3d 463, 470 (4th Dist. 2011) (*citing University of Illinois v. Industrial Comm'n*, 232 Ill. App. 3d 154, 164 (1st Dist. 1992)). Whether a medical expense is either reasonable or necessary is a question of fact to be resolved by the Commission, and its determination will not be overturned on review unless it is against the manifest weight of the evidence. *F&B Manufacturing Co. v. Industrial Comm'n*, 325 Ill. App. 3d 527, 534 (1st Dist. 2001).

As explained more fully above, the Arbitrator finds that Petitioner's current condition of ill-being in the lumbar spine is causally related to his injury at work to the extent opined by Dr. VanFleet through March 1, 2014. The medical bills submitted into evidence related to Petitioner's lumbar spine through March 1, 2014 are for reasonable and necessary medical care to alleviate him of the effects of his injury at work. The bills for medical treatment submitted thereafter are not reasonable or necessary.

Thus, the Arbitrator awards the medical bills incurred by Petitioner for treatment through March 1, 2014 that remain unpaid to be paid by Respondent as provided in Sections 8(a) and 8.2 of the Act. Petitioner's claim for payment of medical bills for treatment rendered after March 1, 2014 is denied.

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 condition of ill-being is causally related to his accident at work to the extent opined by Dr. VanFleet. Thus, the Arbitrator denies the recommended prospective medical care prescribed by Dr. Kube.

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

"The period of temporary total disability encompasses the time from which the injury incapacitates the claimant until such time as the claimant has recovered as much as the character of the injury will permit, i.e., until the condition has stabilized." *Gallentine v. Industrial Comm'n*, 201 Ill. App. 3d 880, 886 (2nd Dist. 1990). The dispositive test is whether the claimant's condition has stabilized, i.e., reached MMI. *Sunny Hill of Will County v. Ill. Workers' Comp. Comm'n*, 2014 IL App (3d) 130028WC at *28 (opinion filed June 26, 2014); *Mechanical Devices v. Industrial Comm'n*, 344 Ill. App. 3d 752, 760 (4th Dist. 2003).

Petitioner claims that he is entitled to temporary total disability benefits for a disputed period beginning May 7, 2014 through September 22, 2015. As explained more fully above, the Arbitrator finds that Petitioner's current condition of ill-being in the lumbar spine is causally related to his injury at work to the extent opined by Dr. VanFleet through March 1, 2014 at which point he was released to full duty work. Thus, Petitioner's claim for temporary total disability benefits after March 1, 2014 is denied.

In support of the Arbitrator's decision relating to Issue (O), credit to Respondent, the Arbitrator finds the following:

As the nature and extent of the injury has not yet been determined, Respondent's claim for a credit for a permanent partial disability advance made totaling $1,643.56 is entered and continued to the time of a final disposition of this case either at trial or via settlement. Other credits claimed by Respondent as agreed by Petitioner for temporary partial disability benefits pain and nonoccupational indemnity benefits paid are reflected in the Arbitration Decision Order form above. *See also* AX1.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Rondal Dean Leeman, Jr.,

Petitioner,

vs.

NO: 14 WC 35067

17IWCC0017

Cargill,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issue of nature and extent, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof, and makes the following special findings, as requested by Respondent pursuant to Rule 7040.40(c) of the Rules Governing Practice Before the Commission.

Respondent requested special findings with respect to the following interrogatories:

1) "Interrogatory 1. What evidence would justify the Arbitrator finding that Petitioner's permanent disability represents 15 times his impairment rating according to the Guides to the Evaluation of Permanent Impairment, Sixth Edition?"

The Commission notes that the Act specifically states "… [n]o single enumerated factor shall be the sole determinant of disability." §8.1b(b). Along these lines, the appellate court recently noted in *Con-Way Freight, Inc. v. Illinois Workers' Compensation Commission*, 2016 IL App (1st) 152576WC, that §8.1b does "not specify the weight that the Commission must give to the physician's report." *Con-Way Freight*, No. 1-15-2576WC, p.8; citing *Continental Tire of the Americas, LLC v. Illinois Workers' Compensation Commission*, 2015 IL App (5th) 140445WC, 43 N.E.3d 556. Furthermore, the court stated "[n]othing within this statutory language allows us to require the Commission to treat the impairment rating as the 'primary factor.'" *Id.*, p.9.

As a result, the Commission finds that the impairment rating is but one factor to consider in evaluating Petitioner's permanent disability and, as the Arbitrator correctly noted, "... does not equate to disability." Rather, the factors enumerated by the Arbitrator – including Petitioner's advanced age, the heavy duty and labor intensive nature of his job, his current complaints relative to his injured, dominant arm, and his objective findings, in addition to the impairment rating by Dr. Li – when considered in their entirety, supports the Arbitrator's permanency determination.

2) "Interrogatory 2. In comparing Petitioner's trial testimony to the treating medical records and Petitioner's own written statement at the time of the impairment rating, would you conclude that there are inconsistencies between Petitioner's subjective complaints at trial and the corroborating medical records?"

The Commission finds that any differences between Petitioner's trial testimony, treating medical records and his written statement regarding his subjective complaints were minimal and by no means dispositive on the question of permanency. Furthermore, the Commission once again notes that such evidence of disability would be but one factor to consider in making any permanency determination.

3) "Interrogatory 3. Based on the impairment rating, the fact that the Petitioner returned to his pre-injury position and is now earning more money, the age of Petitioner and the documentation in the treating records, would you agree that all five factors pursuant to Section 8.1b of the Act should reduce Petitioner's permanent partial disability? Pursuant to the Appellate Court case of *Cornbelt Energy Corp. v. Illinois Workers' Compensation Commission*, No. 3-15-0311WC (2016), do you agree that the Arbitrator did not explain the relevance or weight he attributed to each factor when determining Petitioner's level of disability?"

As previously stated, the Commission finds adequate support in the record to justify the Arbitrator's permanency evaluation, and that the Arbitrator sufficiently explained the relevance and weight accorded each factor in making such an award. To wit, the Arbitrator gave weight to the nature of Petitioner's job as a fumigator, and the need to lift heavy spouts during the day, his complaints of tenderness and aches relative to his injured arm, and the fact that his job requires that he regularly use his injured/dominant right arm. In addition, the Arbitrator specifically noted that he assigned "moderate weight" to Petitioner's age at the time of the injury (54), "no weight" to any impairment in future wage earning capabilities, "some weight" to the impairment rating of Dr. Li, and "moderate weight" to the objective deficits referenced in the physical therapy records. Thus, the Commission finds that the Arbitrator adequately considered and explained all five (5) of the factors enumerated in §8.1b of the Act in reaching his decision, and that as such a reduction in said award was not warranted under the circumstances.

Therefore, the Arbitrator's decision is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed 7/7/16 is hereby affirmed and adopted.

17IWCC0017

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $50,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JAN 19 2017
o: 12/19/16
TJT/pmo
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

LEEMAN JR, RONDAL DEAN
Employee/Petitioner

Case# **14WC035067**

CARGILL
Employer/Respondent

17IWCC0017

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

If the Commission reviews this award, interest of 0.34% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0157 ASHER & SMITH
CRAIG SMITH
1119 N MAIN ST PO BOX 340
PARIS, IL 61944

0332 LIVINGSTON MUELLER O'BRIEN
KENNETH S BIMA
620 E EDWARDS ST PO BOX 335
SPRINGFIELD, IL 62705

17IWCC0017

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

RONDAL DEAN LEEMAN, JR.
Employee/Petitioner

v.

CARGILL
Employer/Respondent

Case # **14** WC **35067**

Consolidated cases: _____

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Douglas McCarthy**, Arbitrator of the Commission, in the city of **Urbana**, on **May 13, 2016**. By stipulation, the parties agree:

On the date of accident, **June 13, 2014**, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $**57,492.24**, and the average weekly wage was $**1,105.62**.

At the time of injury, Petitioner was **54** years of age, ***married*** with **0** dependent children.

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

Respondent shall be given a credit of $**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**.

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

ORDER

Respondent shall pay Petitioner the sum of **$663.37**/week for a further period of **75** weeks, as provided in Section **8(d)(2)** of the Act, because the injuries sustained caused **15% loss of use of person as a whole.**

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

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

D. Glenn McEvoy 7/3/2016

Signature of Arbitrator Date

FINDINGS OF FACT

The parties stipulated that Petitioner was an employee of the Respondent on June 13, 2014. They further stipulated that the Petitioner gave the Respondent notice of the accident within the time limits stated in the Act. They further stipulated that the Petitioner sustained an accident which arose out of and in the course of his employment, and that his current condition of ill-being is causally connected to this injury.

The Petitioner, Rondal Dean Leeman, Jr. (hereinafter referred to as Petitioner), testified that on June 13, 2014, he was setting up a railcar for production, which means that he was going to hang a spout from a conveyor. He was standing on top of the open railcar and was reaching out with his left hand to support himself as he stepped, crossing the railcar, and the wheel that opens the conveyor came apart in his hand. He dropped the spout, and grabbed his lanyard that was on his harness to catch himself from falling into the railcar. He was holding onto the spout with his right hand, and immediately felt pain in his right shoulder.

Following the injury, Petitioner began receiving medical treatment from Dr. Gary Ulrich, an orthopedic surgeon in Terre Haute, Indiana. Dr. Ulrich's medical record states that the Petitioner sustained a violent type of jerking injury to his right shoulder. He reviewed the MRI, which showed a full thickness cuff tear, and recommended open repair rotator cuff surgery.

On October 1, 2014, Dr. Ulrich performed surgery, consisting of right shoulder rotator cuff repair and labral anterior to posterior tear of the right shoulder. His post-operative diagnosis was chronic impingement rotator cuff tear of the right shoulder with superior labral anterior to posterior tear of the right shoulder. Petitioner returned to work on November 2, 2014, with the restriction of no use of right arm, and was to continue with physical therapy.

Petitioner continued to followup with Dr. Ulrich through April 2, 2015, when he was returned to full duties, no restrictions, and had reached MMI.

The Petitioner testified that his current job is one of a licensed fumigator. He is in charge of getting railcars ready to go out to customers in the mornings, and in the evenings to clean the empty railcars when they come back in. He stated that while performing his duties, he notices that his right shoulder is tender, and that the following morning after a day of work, his shoulder is slow to cooperate. Petitioner further stated that his right arm is not as strong as his left arm. Petitioner is right-arm dominant.

Petitioner further stated that he now uses his left arm more dominantly than his right arm, that he has lost strength in right shoulder, and that his range of motion is not as good as it was prior to the injury.

Petitioner also stated that he notices during weather changes that his arm becomes numb and sometimes aches. At the end of a workday, he will take ibuprofen or Aleve three or four times per week.

Since returning to work, he has advised his employer through BBS Observations (Behavioral Base Safety Observations), that the spouts, which he works with, are heavy, and operating the heavy spouts causes his shoulder to become painful.

Petitioner testified that he has been a league bowler for approximately 30 years. He stated that following the accident, he has returned to bowling, and has to use a lighter ball, and his average is much less than it was prior to the accident. Prior to the accident, he was a 205+ average bowler, and now he averages 193. He feels that the reduction in his average is due to loss of strength and using a lighter ball. Petitioner also played fast-pitch baseball, but stated that he is now finished playing fast-pitch baseball because his right shoulder is not the same, stating AI will never play again@.

He notices a change in the activities he does around his home due to his injury, specifically noting, that when he push mows the yard, his right arm aches and is weak.

The Respondent called Vince Porter, Petitioner's Superintendent. Mr. Porter stated that he heard the Petitioner state that the spouts are heavy. He also said that the Petitioner has not made any complaints concerning his shoulder to him since his return to full duty work.

CONCLUSIONS OF LAW

The sole issue in this case is nature and extent, and the Arbitrator must refer to Section 8.1(b) of the Act. The Petitioner was, and still is, employed as a fumigator by the Respondent. His job requires him to get railcars ready to go out to customers in the mornings, and in the evenings, to clean and empty railcars when they come in. He is required to lift heavy spouts during the day. He notices that while performing at work, his arm becomes tender and aches, and the following morning after a day at work, his right arm is slow to cooperate. As the job requires the Petitioner to regularly use his dominant right arm, the Arbitrator gives weight to this factor.

At the time of his accident, the Petitioner was 54 years old. He will not have a long period of work with his disability as would a younger individual. The Arbitrator gives moderate weight to this factor.

There was no evidence submitted to show any impairment on his future wage earning capabilities. No weight is given to this factor

The Respondent introduced an impairment rating from Dr. Lawrence Li that found a final upper extremity impairment of 2% and a whole person impairment of 1%. The doctor's examination, performed on April 25, 2016, showed the Petitioner to have some limitations in

flexion, abduction and internal rotation, when compared with the non dominant arm. The doctor also noted no atrophy and equal strength. The Arbitrator notes that the AMA Guides only provide for a rating for one injury while the operative report shows that the Petitioner sustained injuries to both the rotator cuff and labrum. Accordingly, the Arbitrator gives some weight to this factor, but is mindful that an impairment rating does not equate to disability.

Finally, the Arbitrator considers the objective findings of the treating doctor and the treating physical therapist. Dr. Ulrich's note of April 2, 2015, the final release date, does not contain any objective measurements from which the Arbitrator can assess disability. However, the physical therapy summary of March 27, 2015 does contain such information. At that time, the petitioner exhibited slight decreases in abduction and flexion to a degree similar to that found by Dr. Li one year later. The therapists described the deficits as being slight. Strength of the rotator cuff related muscles was basically equal, a finding similar to that seen by Dr. Li. The Arbitrator believes the factor is entitled to moderate weight.

Based upon the factors set forth in the Act, the Arbitrator awards 15% person as a whole disability.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Tracy Melton,

Petitioner,

17IWCC0018

vs.

NO: 12 WC 3520

Passages Hospice LLC,

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 treatment and temporary total disability and being advised of the facts and law, reverses the Decision of the Arbitrator as stated below and finds that Petitioner failed to prove her current condition of ill-being is causally connected to her employment by Respondent. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

On December 19, 2011 Petitioner, a 41-year-old Certified Nurse Assistant, had been working for Respondent as a hospice caregiver for approximately six weeks. She alleged that on that date she sustained an injury to her low back while turning a bedridden patient. She testified that the patient resisted her and pulled her forward over the bed. She testified that as she was pulled forward she felt a pop in her low back and experienced an immediate onset of severe low back pain. Petitioner completed her regular workday without seeking any medical treatment.

On the following day, Petitioner presented to the emergency room at St. Mary's Hospital in Centralia. She complained of low back pain radiating into her right thigh and she reported that she thought she was injured at work lifting and dressing a patient. X-rays of the lumbar spine

showed that Petitioner had degenerative disc disease most severely at the L1-2 and L4-5 levels and anterior osteophytes were apparent at multiple levels. Petitioner reported a medical history of bulging discs "a long time ago." The emergency room discharged her with a diagnosis of low back pain and advised her to take Tylenol or Motrin as needed and remain off of work for three days.

Petitioner followed up with the Work Safety Institute at St. Mary's Hospital in Centralia on December 22, 2011. She was reexamined and referred for physical therapy and a lumbar MRI. The January 13, 2012 MRI was interpreted as showing degenerative disc disease with lateral disc bulges on the right at L3-4 and L5-S1, facet atrophy at L4-5, and ligamentum flavum hypertrophy narrowing the spinal canal at L3-4 and L4-5. Petitioner followed up with Dr. Alan Froehling in Mount Vernon on January 25, 2012.

The medical records show that Petitioner had a history of treatment by Dr. Froehling since 1991 for recurrent low back complaints. Five prior emergency room visits involving low back injuries are documented in the medical records. Petitioner underwent a lumbar CT scan in 1991 and lumbar MRI scans in 1998 and 2006. Lower extremity EMG testing for chronic complaints of bilateral lower extremity pain and numbness was performed ten months before the December 19, 2011 accident.

On January 25, 2012, Dr. Froehling noted that Petitioner had a history of prior disc protrusion and bulges. He did not believe that she was a candidate for surgery and he recommended conservative treatment. He further noted that MRI images from January 13, 2012 were "degraded by the patient's obesity" but appeared to show multiple areas of disc degeneration and small bulges; a small disc protrusion on the right at L3-4 and some marginal stenosis at the L3-4 level. At a follow up visit on February 8, 2012, Dr. Froehling noted that the Petitioner's prognosis was guarded because of her obesity and longtime smoking habit; Petitioner reported no improvement from the prior examination and Dr. Froehling continued to keep her off of work. She returned to Dr. Froehling one final time on February 22, 2012. Dr. Froehling noted that Petitioner attended a few sessions of physical therapy without benefit. He recommended a lumbar epidural steroid injection (ESI) as a next step in treatment. He stated that he anticipated a slow recovery for Petitioner and that he still considered her a poor candidate for surgery.

Respondent sent Petitioner for an independent medical evaluation (IME) with Dr. David Raskas on June 6, 2012. At the 19(b) hearing the Arbitrator admitted the report of Dr. Raskas into evidence as Petitioner's Exhibit 11 over Respondent's hearsay objection. The Arbitrator ruled that the report was admissible as an admission against interest. On review, we reverse the Arbitrator's evidentiary ruling. Dr. Raskas is not an agent of Respondent and his statements do not constitute an admission by a party-opponent under Rule 801(2) of the Federal Rules of Evidence. In *Greaney v. Industrial Comm'n*, 358 Ill.App.3d 1002 (1st Dist. 2005), the Appellate Court addressed the same issue and found no exception to the hearsay rule under which the expert's report could be admitted over a hearsay objection. In the case at hand, we find that the Arbitrator erred in admitting the independent medical examination report of Dr. Raskas over Respondent's hearsay objection and we strike Petitioner's Exhibit 11.

Subsequent to the evaluation by Dr. Raskas, Respondent authorized the requested lumbar injections. Petitioner sought treatment with a new provider, Dr. David Kennedy, rather than continuing care with Dr. Froehling. At her initial evaluation by Dr. Kennedy on July 25, 2012, Petitioner reported having been injured on December 19, 2011 while attempting to roll a hospice patient. She complained of lower lumbar pain radiating into the right hip and thigh with occasional numbness into the right inguinal area and right posterolateral thigh, calf, and foot. With respect to relevant medical history, Petitioner recounted only a "remote history of pain in the lower lumbar area in 1997." Dr. Kennedy noted Petitioner's history of smoking and obesity. He reviewed her January 13, 2012 MRI and diagnosed a lumbar strain with sciatic features. He noted that Petitioner failed to improve with physical therapy. Dr. Kennedy agreed with the recommendation for lumbar injections and he referred Petitioner to Dr. Barry Feinberg for the procedure.

Petitioner underwent a series of three lumbar ESIs in September of 2012. The effects of the first injection into L3-4 lasted for only a few days. The second and third injections were administered into the L4-5 level. Petitioner denied that she received any lasting relief from the injections. As a result, Dr. Kennedy opined that Petitioner had failed conservative treatment and he recommended a lumbar myelogram. On October 31, 2012, Dr. Kennedy interpreted the lumbar myelogram as showing spinal stenosis at L3-4 and L4-5 with severe foraminal encroachment at L5-S1, especially on the right side. Dr. Kennedy recommended a lumbar decompression and fusion from level L3 through level S1. However, noting that Petitioner's weight of 338 pounds was a barrier to surgical intervention, he required that she lose weight. Dr. Kennedy kept Petitioner off of work "pending weight loss and definitive surgical intervention." Petitioner testified that she attempted to lose weight on her own by modifying her diet.

In 2013, Petitioner's workers compensation insurance carrier went into bankruptcy; Petitioner testified that her TTD payments lapsed during this period. The Illinois Guarantee Fund subsequently brought Petitioner current on her TTD benefits and sought an updated independent medical examination. On November 5, 2014, Petitioner was examined by Dr. Daniel Kitchens at the request of Respondent. Dr. Kitchens noted that Petitioner weighed 324 pounds and smoked one pack of cigarettes per day. Petitioner denied any prior back issues or injuries other than a mid-90s work injury where she was told she had a pulled muscle and disc bulging. She reported that she had physical therapy at that time and was off of work for a couple of weeks. However, Dr. Kitchens also reviewed medical records dating back to 1991. Dr. Kitchens diagnosed Petitioner with lumbar degenerative disc disease with right sided disc bulging and right sided foraminal stenosis. He opined that all of these conditions were present in 2006 and noted on the MRI at that time. He noted, "Upon direct comparison of the 2012 and 2006 lumbar MRIs, I see no significant change or worsening of the disc bulging to the right side at L5-S1." Dr. Kitchens opined that "Prior medical records therefore make it impossible for the degenerative changes and disc bulge to be related to the December 2011 work incident." He found Petitioner required no treatment or restrictions and he opined that she was at maximum medical improvement for the work accident of December 2011. After receiving the report of Dr. Kitchens, Respondent ceased payment of workers compensation benefits to Petitioner.

The Arbitrator found no reasonable basis for Respondent to have denied Petitioner's previously-accepted claim. For the reasons stated below, we disagree. We find that Petitioner

failed to prove her alleged current condition of ill-being is causally related to the December 19, 2011 accident. We find that Petitioner is not entitled to temporary total disability benefits or medical expenses after November 5, 2014 based on the credible medical records and the opinions of Dr. Kitchens, which we find more persuasive than the opinions of Dr. Kennedy. We therefore deny Petitioner's claim for workers compensation benefits pursuant to §19(b) and remand this case to the Arbitrator.

Dr. Kennedy and Dr. Kitchens, both board-certified neurosurgeons, testified in this matter via deposition. Dr. Kennedy testified that Petitioner reported to him that she had some prior "similar issues" in 1997. Dr. Kennedy testified that he reviewed the IME report of Dr. Kitchens in advance of the deposition but it did not change his opinions. Dr. Kennedy noted that Dr. Kitchens reviewed medical records dating back to the 1990's. Nevertheless, Dr. Kennedy testified that he disagreed with the opinion of Dr. Kitchens that the evidence showed that the accident could not have caused significant changes from Petitioner's pre-accident condition. Dr. Kennedy testified that in his own review of the 2006 MRI, he saw no bulge or protrusion. He testified that compared to 2006, the 2012 MRI is "a lot worse" with respect to the L4-5 level.

Dr. Kennedy explained his diagnosis and basis for recommending surgery. He explained that the myelogram showed L3-4 disc bulging, which corresponds to Petitioner's pain complaints. Furthermore, the temporary response to the injection at L4-5 indicated that level was also symptomatic. Dr. Kennedy concluded that these levels are the source of Petitioner's pain and he recommended a lumbar decompression and fusion from L3 to S1. He believed that extending the fusion to S1 was preemptive; he would expect future disc collapse at L5-S1 without it.

Dr. Kennedy testified that Petitioner would probably need weight loss surgery due to her size and inability to lose weight on her own. Dr. Kennedy testified that Petitioner should remain off of work pending surgery.

On cross-examination, Dr. Kennedy admitted that he did not personally review all of Petitioner's prior medical records. He did not review Petitioner's records and lumbar CT from St. Mary's Hospital from 1991 when she presented with complaints of low back pain and radiation to the right leg after moving a patient at work. He did not review Petitioner's emergency room records from 1995 when she presented with complaints of low back pain, left leg pain, and shooting pains while walking that occurred after lifting a resident at work. He did not review Petitioner's emergency room records from 1997 after she fell down her stairs. He did not review Petitioner's medical records including a lumbar x-ray from 1998 showing L4-5 degenerative disc disease. At that time, Petitioner had complaints of popping and pain in the low back and radiating into both buttocks while transferring a patient at work. He did not review the lumbar MRI from 1998 that was ordered by Dr. Froehling and interpreted as showing degenerative changes at L4-5 and L5-S1 with bulging at L5-S1 and a protrusion into the neural foramen on the left at L4-5. He did not review Petitioner's lumbar x-ray from August of 1998 showing a compromised L4 nerve root at L4-5 and degenerative disc disease with Schmorl's nodes on the right of the posterior lateral S1 superior end plate. He did not review Petitioner's emergency room records or the lumbar x-ray pertaining to a June 25, 2001 injury where Petitioner fell in a hole in her yard and complained of right hip, leg, and back pain including jolts and throbs of pain

down the right leg. Dr. Kennedy did not review records from Petitioner's primary care provider, PA-C Hummel. Finally, Dr. Kennedy agreed that he never saw the emergency room records from St. Mary's Hospital following the December 19, 2011 accident. Dr. Kennedy agreed that he did not have the opportunity to review the 2006 MRI until recently, prior to his deposition. Dr. Kennedy agreed that his causation opinion is based in part on the history Petitioner gave to him.

Dr. Kennedy agreed that smoking is a risk factor in non-fusion and he has counselled Petitioner to quit smoking. Dr. Kennedy agreed that Petitioner drives to appointments and does not use any assistive devices. Dr. Kennedy agreed that Petitioner is not completely unable to work a sedentary job, but he testified it is his recommendation that Petitioner should not work at all because the priority should be getting her "fixed."

Dr. Kennedy agreed that his office records note that Petitioner sustained further injuries since December 19, 2011. In December of 2013 she reported a fall onto her left knee. In May of 2014 she reported slipping in the shower resulting in a neck strain. In September of 2014 she reported falling down the stairs causing increased low back pain.

On redirect examination, Dr. Kennedy opined that he did not believe any further injections or physical therapy would be beneficial for Petitioner. He testified that she must lose weight in order to be a surgical candidate; however, in his opinion smoking is not an absolute barrier to going forward with surgery. On further cross-examination, Dr. Kennedy agreed that Petitioner would need to have further testing to make sure she is otherwise healthy enough for surgery.

Respondent's independent medical examiner, Dr. Kitchens, testified that he questioned Petitioner regarding her medical history. He testified that Petitioner described having previously experienced only a pulled muscle and disc bulging in the mid-1990s related to a work injury and she denied any other back problems. Dr. Kitchens reviewed medical records dating back to 1991 and he inspected the films from the January 13, 2012 and September 26, 2006 lumbar MRIs. Dr. Kitchens found that the documented evidence of Petitioner's medical history was inconsistent with her subjective history.

In reviewing and comparing the 2006 and 2012 lumbar MRIs, Dr. Kitchens testified that both showed degenerative disc disease at L4-5 and L5-S1, foraminal stenosis to the right at L5-S1 with modic-type endplate changes, and an annular bulge to the right side at L5-S1. He opined that there was no significant change or worsening between the 2006 and 2012 films. Dr. Kitchens testified that the only positive findings on physical examination of Petitioner were subjective findings such as pain with extension and flexion. He explained that Petitioner's straight leg raise test was invalid because it yielded inconsistent results with seated and supine testing. Dr. Kitchens concluded that there was no clinical evidence of radiculopathy. There was no objective evidence of weakness in Petitioner's right leg or foot, she had normal strength, and her gait was steady.

Dr. Kitchens testified that his opinion, within a reasonable degree of medical certainty, was that the December 19, 2011 accident did not cause or permanently aggravate Petitioner's current condition of ill-being of lumbar degenerative disc disease, neural foraminal

impingement, and disc bulging at L5-S1. Dr. Kitchens opined that no further treatment was necessary and that Petitioner was at maximum medical improvement from the accident. Dr. Kitchens opined that Petitioner does not require any work restrictions related to the accident.

On cross-examination, Dr. Kitchens agreed that he did not see any records indicating that injections or surgery were ever recommended prior to the December 19, 2011 accident. However, he disagreed that Petitioner's condition "resolved" after every prior instance of back pain or injury as her condition is longstanding and degenerative.

In resolving disputed issues of fact, it is the province of the Commission to weigh the credibility of witnesses, draw reasonable inferences from the evidence, determine what weight to give testimony, and resolve conflicts in the evidence. After considering all of the evidence, we reverse the Arbitrator's decision on the issue of causal connection. We find that Petitioner's failure to disclose relevant medical history negates the persuasiveness of any causal opinion based significantly on Petitioner's subjective history. Even when directly questioned at arbitration, Petitioner answered vaguely and denied any recollection of some medical history documented in her medical records. In finding that Petitioner failed to prove her current condition of ill-being is causally related to her employment by Respondent, we rely on the opinions of Dr. Kitchens. Dr. Kitchens had the benefit of reviewing Petitioner's prior medical records. He opined that the medical evidence fails to show any significant change from Petitioner's pre-injury condition. We find that Petitioner reached maximum medical improvement for the December 19, 2011 accident by the time she was examined by Dr. Kitchens on November 5, 2014. The parties agree that Petitioner was paid workers' compensation benefits until the report of Dr. Kitchens was received. We vacate the Arbitrator's award of TTD and medical expenses after November 5, 2014. Finally, we reverse the arbitrator's evidentiary ruling admitting the report of Dr. Raskas for the reasons set forth above and we remand the case to the Arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $413.33 per week for a period of 150 and 2/7 weeks from December 20, 2011 through November 5, 2014, that being the period of temporary total incapacity for work under §8(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall be given a credit of $61,999.50 for temporary total disability benefits that have been paid.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay reasonable and necessary medical services of $19,288.21 for medical expenses under §8(a) and §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall be given a credit for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in §8(j) of the Act.

17IWCC0018

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $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 19 2017
RWW/plv
o-12/7/16
46

Ruth W. White

Joshua D. Luskin

Charles J. DeVriendt

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JAMES BURNS,

Petitioner,

17IWCC0019

vs.

NO: 14 WC 12387

SPEEDCO & ABC AUTO AUCTION,

Respondents.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by Respondent, Speedco, herein and notice given to all parties, the Commission, after considering the issues of accident, notice, causation, temporary total disability, penalties and fees, and medical expenses both current and prospective, and being advised of the facts and law, reverses the Decision of the Arbitrator, finds that Petitioner did not prove compensable accidents, and denies compensation.

By way of background, Petitioner filed three separate claims naming both Speedco and ABC Auto Auction as respondents. Petitioner alleged different accident dates but alleged injuries to the same parts of the body caused by "repetitive walking activities" in all claims. The three alleged accident dates were the date Petitioner sought treatment, the date he last worked for Speedco, and the date he last worked for ABC Auto Auction. The claims were consolidated and arbitrated together. The Arbitrator issued three separate decisions disposing of each claim individually. In 14 WC 41057 The Arbitrator found ABC Auction not liable because he found Speedco was liable in the other claims (14 WC 12387 and 14 WC 41044), based on his determination that Petitioner's alleged injuries arose out of work activities performed during his employment with Speedco. ABC Auction moved to dismiss the Petition of Review filed by Speedco, in 14 WC 41057. The Commission denied that motion. By separate decisions, the Commission also reverses the Decision of the Arbitrator in 14 WC 41044 and affirms the Decision of the Arbitrator in 14 WC 41057.

Findings of Fact and Conclusions of Law

1. Petitioner testified on November 6, 2013 and February 14, 2014 he was employed by Speedco and April 15, 2014 he was employed by ABC Auto Auction. At Speedco he changed oil, changed tires, and performed preventative maintenance on diesel trucks. He had worked full time for Speedco for about seven or eight years. In November 2013 he was crew chief at Speedco, and had been for two to three years. He was scheduled to work eight hours a day and was able to take lunch "sometimes," but "most of the time *** it was busy, couldn't do that." In the month prior to November 2013 Petitioner's job became harder because there were a lot of new people after "the whole crew quit."

2. Petitioner's job responsibilities "were to of course sell stuff to the drivers, check the guy that's in the pit which is downstairs, check his work to make sure he did his work right, check his grease fittings, torque his plugs, the oil pan plugs, check tires." Besides checking on the work of the downstairs-guy, Petitioner was supposed to check "the whole top of the truck," check all 18 tires, add air if needed, and change fuel filters.

3. At Speedco there were five bays; "plenty of times" he would be in charge of all of them. On days in which he was the only crew chief, he did "quite a bit" of walking and was on his "feet all day long, all day long." He would not be able to take lunch breaks on those occasions. He would have to walk downstairs for every truck that was serviced. "Sometimes you'd do ten, some days you'd do 20." He would also have to walk the length of the truck, and "check all the fittings" if there was a trailer attached.

4. Petitioner also testified that Respondent's job description indicating he was on his feet 90% of the time was accurate. He could sit only when there were no customers. "It was a weird place to work, some days you wouldn't do any trucks or a couple, some days you'd do 20 and you wouldn't have a chance to do anything, you know."

5. The floor was concrete and the stairs were metal; "it was a slippery place" with oil and grease. One reason they issued work boots was because they were slip resistant. Employees ordered the boots through the Speedco distributor. The handbook provided that employees had to wear boots approved by Speedco. He believed Speedco paid for the boots. Boots would last about six months because they would deteriorate due the oil, grease, and water, but Respondent would only replace them once every year. "When you first put on the boots they were all right but after, you know, after an hour or so they're terrible, they rubbed – they were just terrible boots." They fit snuggly at first, but then "they loosened up and it's like your feet were flopping around inside the boot."

6. Petitioner began to develop problems with his feet while working for Speedco. He first noticed a burning sensation in the back of the right foot; he could not bend it. He noticed the problem using stairs, and did not have the problem when in his street shoes.

7. Normally, his feet would feel better after resting at home. He reported the condition "the day it wouldn't quit hurting." In November 2013 he had to stop working because of his right foot; he couldn't walk, couldn't stand, and had to drag his foot while walking because he could not bend it. He went to a hospital emergency department on November 6, 2013. When Petitioner went for treatment for his right foot, he also had symptoms in the left foot, but the problem was primarily on the right.

8. Petitioner was referred to Dr. Scherer from the emergency department. He had not treated for his feet previously. Petitioner then testified he had treatment for his right foot when he was 18 or 19 after he "dropped a motorcycle" on it. However, that was by his toes and in a different part of his foot than where he was having current problems.

9. Petitioner also testified that it sounded correct that he told Dr. Scherer that he walked 10 miles a day. He did not "know if it was actually 10 miles, you know, but it felt like 10 miles." Dr. Scherer prescribed a Cam boot and physical therapy and took him off work. Dr. Scherer released him to return to work on around December 3, 2013. Petitioner had to do the same amount of walking upon his return. He believed he had new boots when he came back to work. Symptoms in his right foot were tolerable for about a week, but then it "started up again." Within "a month tops" from returning to work he developed problems with his left foot as well; same as the right but less intense.

10. Petitioner told the assistant manager about problems with the left foot. That conversation was prior to his leaving Speedco. He left Speedco on February 14, 2014 because he "couldn't do it anymore, it hurt too bad" in his feet and ankles. He was not treating at that time and had no other job lined up. Petitioner wanted treatment for his feet and that was about the time he talked to his lawyer.

11. Petitioner thought he began working for ABC Auto Auction about a month after leaving Speedco. He got the job because a friend of his was a friend of the manager. He explained to the manager that he might have to take some time off to see a doctor for his feet. He worked as a mechanic for ABC Auction and did not have to do the same amount of walking/standing than he did at Speedco; "instead of walking around a big giant truck" he was "walking around a little car on a lift." He was able to take breaks and had had an hour lunch every day.

12. At ABC Auto Auction, Petitioner job was to "repo cars, stuff like that, fix stuff that was wrong with them, and they'd go to the auction on Thursday." He did not wear the Speedco boots on this job, and never wore those boots after leaving Speedco. He wore boots like police wear and tennis shoes at ABC. The change in footwear and job activities helped his feet "tremendously." However, his symptoms never went away completely.

13. Petitioner saw Dr. Mall on April 18, 2014. He discussed with Dr. Mall his respective job activities with Speedco and ABC. He "guessed" the first time ABC was "told of this work injury" at Speedco was after he saw Dr. Mall. However, Petitioner also testified that the manager knew about his feet the day he started at ABC. Dr. Mall has prescribed orthotics, medication, and physical therapy. Petitioner had to stop working for ABC because he "couldn't do it; it hurt." He thought the condition was a continuation from the work at Speedco, but thought he should give the job with ABC a try.

14. In June 2014 he began working for Jerry's Tires, where he performs maintenance of cars. He does not have to wear boots and wears tennis shoes, which are pretty comfortable. There are no walking requirements at Jerry's and his feet felt "pretty good actually." His feet actually "didn't even bother" him for two months. However, he was still having problems with his feet.

15. Speedco sent Petitioner to Dr. Schmidt. He asked Petitioner about his job activities at Speedco, ABC, and Jerry's. It was Petitioner's understanding that Dr. Schmidt agreed with Dr. Mall's recommendation for prospective treatment. It was also his understanding that Respondent had sent an e-mail indicating they were going to authorize treatment for the right foot, but no treatment had been authorized.

16. ABC sent Petitioner to Dr. Krause. Petitioner told Dr. Krause about his work activities at Speedco and he thought he told him about the boots. Petitioner would not want to return to work with Speedco, because his feet hurt too much; there was no way he could walk around there like he used to. Petitioner was rear-ended in a motor vehicle accident on November 23, 2013 and received treatment for injuries sustained in the accident. However, he did not injure his feet in the motor vehicle accident.

17. On cross examination from Speedco, agreed that he testified it felt like he walked 10 miles, but he did not measure it and "it might have been an exaggeration" but "it was a lot." There was a cashier who wore a pedometer which indicated she walked 22 miles a day, so he "was kind of going by that." Petitioner did not inform Speedco about his alleged February 14, 2014 accident; he did not talk to anybody there after he left.

18. Petitioner also testified his condition varies. Some days he has no pain and some days he cannot walk. Petitioner testified he walked on concrete and asphalt at ABC. However, the workspace at ABC was much smaller than at Speedco and he wore comfortable shoes. Working on cars at ABC involved about the same squatting and crawling as his job with Speedco. Petitioner has not had treatment for his left foot.

19. In the motor vehicle accident he did not slam his "feet down" but he did slam his head against the roof and had a bruise on his chest from the seatbelt. Petitioner agreed that he worked over time almost every week while he was at Jerry's.

20. On redirect examination, Petitioner testified after he returned to work at Speedco in December 2013 until he left on February 14, 2014, he told his supervisor, Russ Oliver, about problems with his left foot. He did not tell him that his problems were related to his work. Petitioner testified that he was prescribed medication by Dr. Mall, but he developed chest pain, which was warned on the label. He threw them in the trash. He mostly takes Ibuprofen. Petitioner reiterated that he was having problems with both feet when he began working for ABC.

21. Sean Miller was called by Speedco, for which he works as general manager supervising employees. Prior to his current position, he worked as technician and crew chief, which was the same job Petitioner had in 2012 and 2013. Mr. Miller was a crew chief for three years. When asked how long a crew chief is standing the witness answered "maybe four hours tops." He actually put a pedometer on a crew chief. He walked one and a half miles on a slow day and three miles on a busy day. He did not think he ever walked 10 miles on any day he was crew chief. On an average day there is "maybe three hours of down time." Mr. Miller testified that during down time they "most likely cleaned the shop or whatever" because "nobody likes to sit around for three hours."

22. Mr. Miller also testified he had a conversation with Petitioner on his last day of work. He asked Petitioner why he was quitting and he responded "that he was just tired of Speedco and all the new guys and he was fed up and he quit." He made no comments about his feet. He prepared the termination form submitted into evidence.

23. On cross examination, Mr. Miller agreed that Russ Oliver is an assistant manager at Speedco. He had a "number of crew chiefs who left" in 2013. He had to stretch out the shifts of crew chiefs and he was not always on the same shift as Petitioner. He agreed that Petitioner was supervising new mechanics, that new employees required greater supervision, and that was a reason for his quitting. However, there was usually somebody downstairs training a new guy so the crew chief would not have to go up and down the stairs. He agreed with Speedco's description of the job of technician requires standing for 90% of the time. Standing could include walking.

24. On November 6, 2013, Petitioner executed an accident/illness report, in which he indicated he was "just doing normal duties at work, walking, standing, going up and down stairs on hard concrete floor wearing steel toed shoes." He experienced Achilles tendon pain. Petitioner marked both that the accident was work related and not work related because his claim was denied so he was unsure. There is also an attestation from Dr. Scherer that Petitioner was restricted to seated work only and was using a crutch and walking boot. He was released to full duty as of December 2, 2013.

25. On November 11, 2014, Dr. Mall, a board certified orthopedic surgeon with fellowships training in sports medicine and shoulder surgery, testified by deposition. He treats

injuries to the feet. He sees the type of condition Petitioner had, which is common among "runners and people who are on their feet quite a bit."

26. Dr. Mall first saw Petitioner on April 15, 2014 and he "could have been" referred by Petitioner's lawyer. He received a letter from the lawyer's office with accompanying records. Petitioner reported he started having pain in his ankles into his feet bilaterally. It got more and more severe and he sought treatment in November 2013. He was referred to Dr. Scherer by the emergency department for right-sided Achilles tendon pain. Petitioner reported to Dr. Scherer that he walked 10 miles per day on concrete in work boots. The symptoms and history were similar to that he gave to Dr. Mall, except that "both feet were kind of bothering him when he came to see" him.

27. Petitioner reported that at Speedco he worked eight hour days with minimal breaks and had some over time. He walked on concrete floors in work boots. His pain got better when he took some time off and returned when he came back to work. That told Dr. Mall "that there's something about his work that seems to be causing or contributing to his discomfort." He had started working for ABC which was somewhat easier, but he still had the pain and had to stop working there on April 1, 2014.

28. Petitioner complained of pain over the Achilles tendon on both heels with some pain over the plantar fascial insertion. His pain was worse on the first steps of the morning, improved after "he's kind of warmed up," and worsened by the end of the day after being on his feet for a long period of time. Petitioner's report of his activities is similar to those he sees in other patients with Achilles tendonitis. Runners who run on hard surfaces are particularly at risk.

29. Regarding Petitioner's experiencing symptoms, Dr. Mall focused on Petitioner's walking on concrete surfaces and on his feet for eight to 10 hours a day with minimal breaks. He also noted that poor shoes can be a factor in causing these symptoms. Running as a causative factor for Achilles tendonitis is "all over the literature." Studies have also shown being on one's feet for a prolonged period of time is a causative factor for plantar fasciitis symptoms. Dr. Mall explained "planter fasciitis and Achilles tendonitis are very similar processes, whether or not you have pain on the top part of the calcaneus or the bottom part of the calcaneus." Dr. Mall cited a study in the Journal of Bone & Joint Surgery, which he deemed probably the most rigorously vetted journal in the field.

30. In looking at the coincidence of Petitioner's work and his symptoms Dr. Mall opined that "clearly it was coming from his work." "That's when he started denoting the symptoms, and, again, when he stopped working and then felt better and then went back to work and then it came back again." Petitioner had no other activities that would cause a risk factor for the condition. Dr. Mall explained that a person can have Achilles tendonitis demonstrable on MRI and not have any symptoms.

31. On examination, Petitioner exhibited signs of Achilles tendonitis and plantar fasciitis. However, he did not note any redness or dramatic deformity in the heels, though he may have had some swelling. X-rays showed some small calcified densities in the Achilles tendon insertion bilaterally, which was another indication of Achilles tendonitis. Dr. Mall also believed Petitioner had some plantar fasciitis as well, especially on the left. Dr. Mall recommended conservative treatment including splints, physical therapy, anti-inflammatories, and better footwear or orthotics. Dr. Mall did not believe any treatment had been authorized and that Petitioner had not been able to start physical therapy. He believed Petitioner had some stomach issues with the anti-inflammatories and had to stop them. Dr. Mall seemed to indicate that even though his work activities at ABC were lighter, his condition worsened due to lack of physical therapy.

32. Currently, Dr. Mall recommended custom shoe inserts. Topical gel and the use of tennis shoes had not worked for him. If Petitioner's condition continued to be sufficiently debilitating, he would consider surgery. The exact nature of the surgery would depend on MRI findings. Dr. Mall has not yet recommended surgery, and just began the conversation with Petitioner. There are also additional conservative treatment modalities that could be used. He would start with physical therapy.

33. Dr. Mall expected that if further treatment was not approved, Petitioner would continue to have symptoms. Dr. Mall was concerned that Petitioner was getting to the point that they would have to consider "kind of an escalation of treatment," because he had been persistently symptomatic for about six months.

34. Dr. Mall reviewed the report of Dr. Schmidt, Speedco's Section 12 medical examiner. He diagnosed retrocalcaneal bursitis. Dr. Mall is familiar with that diagnosis. He explained that "the retrocalcaneal bursitis is basically overlying the Achilles tendon. It's basically the same thing. To really be able to say one versus the other you'd probably have to get the MRI to see where the issues are coming from." The symptoms for the conditions are almost identical and the conservative treatment would be the same. Dr. Mall also noted that he did not see that Dr. Schmidt reviewed the x-rays which "would probably let him change that diagnosis to Achilles tendonitis" because it showed the calcium deposits. He agreed with Dr. Schmidt's opinion that Petitioner's condition was caused by his work as a crew chief for Speedo.

35. Dr. Mall also testified that Petitioner brought in the work boots he used at Speedco for 2&½ months; "the whole toe box was torn on both shoes. Both shoes had tearing on the back side of the heel area where the Achilles to kind of sitting." "The inner part of the boot was pretty beat up." He thought the boots were not "super high quality or at least that they are getting worn out in that 2&½ months, which is a pretty short period of time for the boots to look that bad." The condition of the boots "could potentially relate to some of his symptoms."

36. On cross examination, Dr. Mall testified that about 5% to 10% of his practice involved treatment of ankles. He agreed that Petitioner told him he walked approximately 10 miles a day. Petitioner also stated that a majority of the day he spent on his feet. Dr. Mall also agreed that the initial records mentioned only problems with his right foot. Nobody can really know how long it took to develop the conditions found by the radiologist in the x-rays taken at the emergency department. However, he agreed it was not an acute process.

37. Dr. Mall also testified that the lag in the onset of symptoms in the left foot could simply have developed after November 16, 2014 and when he left Speedco. Also, wearing a Cam boot can alter the patient's gait and cause symptoms on the other side. Differences in his specific treatment notes about symptoms can be attributable to the natural waxing/waning of symptoms.

38. Dr. Mall denied that he stated that Petitioner's work for Speedco was the cause of his condition. He said "that his symptoms initiated when he was working for Speedco. That's when his symptoms started, and they have never completely resolved." It was possible that he was still walking on concrete and continuing to aggravate his condition. However, he also did not receive the treatment Dr. Mall prescribed.

39. On May 5, 2015, Dr. Krause examined Petitioner at the request of ABC Auto Auction and issued a report pursuant to Section 12 of the Act. Petitioner reported working at Speedco in 2013 as crew chief. In June 2013 many people quit and he was required to do a lot more walking on both flat surfaces and up/down stairs. He started getting pain in his heels while working which became much worse in November 2013. On November 6, 2013 he went to the emergency department at Anderson Hospital. Dr. Krause then summarized treatment and other documentation.

40. Petitioner reported he was no longer working at Speedco but was then at Jerry's Tires. He had no physical therapy and essentially no conservative treatment. He gets pain bilaterally, worse on the right. Dr. Krause's exam appears to have been normal. Dr. Krause reviewed x-rays and MRIs. After his review of the record, tests, and examination, Dr. Krause diagnosed bilateral insertional calcific Achilles tendonitis with no evidence of plantar fasciitis. He then answered interrogatories.

41. Dr. Krause opined that the Achilles tendonitis predated the accident date of November 6, 2013. He agreed with Dr. Schmidt that the work activities at Speedco/ABC were not causally related to his chronic tendonitis. He noted that Dr. Mall was correct that symptoms of Achilles tendonitis wax and wane over time but he found "odd" that Petitioner did not have symptoms prior to November 6, 2013, but just because the symptoms while working did not mean the activities caused the condition.

42. Dr. Krause indicated that Petitioner's activities at Speedco would have exacerbated his "preexisting insertional Achilles tendonitis but it did not change the natural history of the disease process." Dr. Krause opined that Petitioner was at maximum medical improvement from his presumed injury of November 6, 2013, and could return to work with no restrictions.

43. Dr. Schmidt testified by deposition on August 12, 2015. He was been a board certified orthopedic surgeon for 18 years. He restricts his practice to treatment of the foot and ankle, performing between 300 and 450 surgeries annually. He has treated patients with Achilles tendonitis, retrocalcaneal bursitis, and plantar fasciitis. He explained that retrocalcaneal bursitis is an inflammation of the retrocalcaneal bursa, insertional Achilles tendonitis is an inflammation of the tendon as it inserts into the bone, and plantar fasciitis typically is inflammation of the ligament in the area where it hooks into the heel bone.

44. At the request of Speedco, he saw Petitioner twice for Section 12 medical examinations, the first time on July 24, 2014. Petitioner reported the gradual onset of bilateral ankle pain starting around November 6, 2013, "he attributed to repetitive walking, climbing, kneeling steel-toed boots and concrete floors." He felt his job changes because of new hires which increased his activities. By November 6, 2013 his right foot swelled and he had difficulty walking. He sought medical treatment at that time. He quit his job because of his ankle pain and the multiple new hires. Petitioner went to ABC Auction and he felt he lasted there about three months; he did not tolerate that job well because of his ankles. He then went to Jerry's Tires, which felt was better for him.

45. Dr. Schmidt's examination of Petitioner was relatively normal, except for tenderness in the retrocalcaneal area. The posterior tibial nerve and tendon, the Achilles tendon, and the calcaneal tuberosity were normal. These are areas associated with ankle/heel pain. Based on Petitioner's report of "a quantum leap in his activities," Dr. Schmidt felt his developing retrocalcaneal bursitis was a distinct possibility. He outlined conservative treatment which he deemed would be of benefit to Petitioner.

46. Dr. Schmidt saw Petitioner again on January 29, 2015. At this time he was provided medical records, which he was not provided prior to the initial examination. He saw an x-ray report of the right foot from the emergency department which indicated chronic Achilles tendonitis and a Haglund's deformity. Dr. Schmidt noted that "people with a Haglund's deformity have a high propensity of Achilles tendonitis." Petitioner then went to Dr. Scherer who prescribed conservative treatment for a diagnosis of acute Achilles tendonitis. Dr. Scherer also noted heterotrophic calcification, which forms over a long period of time and suggests chronic inflammatory change.

47. Dr. Schmidt also reviewed the records of Dr. Mall. Dr. Mall mentioned plantar fasciitis. However, Dr. Schmidt did not find that condition when he examined Petitioner on January 29, 2015. He took x-rays at that time, which showed the Haglund's deformity

and calcific deposits bilaterally. With a bilateral condition "basically it's more common is systemic type situation as opposed to a trauma situation." Dr. Schmidt concluded that Petitioner had bilateral calcific tendonitis, which he did not think was caused by his increased work load while working for Speedco, or his work activities at all. Petitioner would have intermittent flare-ups of his Achilles tendonitis and it would be exacerbated by any standing or walking.

48. Dr. Schmidt did not believe Petitioner was a surgical candidate. "It's a very difficult operation as far as recovery goes," and should be reserved "for rather extreme case and rather debilitating cases." Petitioner was actually functioning quite well. He was shown the MRI report showing 20% and 10% of the Achilles tendons. Dr. Schmidt indicated typically they would not intervene surgically with less than a 50% tear.

49. On cross examination, Dr. Schmidt agreed that Petitioner has right-sided calcified Achilles tendonitis, insertional tendonitis, and retrocalcaneal bursitis. He also agreed that those conditions are aggravated by activities and Petitioner first noted symptoms following work activities at Speedco. Petitioner was still complaining of symptoms when he last saw him on January 29, 2015 and reported no resolution of his symptoms. Dr. Schmidt believed the treatment he recommended in July 2014 would have still been beneficial as of January 29, 2015. He was not aware of any treatment being approved during that period.

50. Hypothetically, if Petitioner had left-sided symptoms while working at Speedco, the activities there would have aggravated his symptoms. He believed that currently Petitioner had the same conditions in his left foot/ankle as he did not the right. It was possible that Petitioner's left foot condition deteriorated when he went back to work for Speedco from December 2013 to February 2014.

51. Dr. Schmidt agreed that he indicated in his report that once a person develops the symptoms Petitioner had it would take a while to resolve them. He also agreed that if Petitioner suffered injuries to his ankles at Speedco, subsequent symptoms while working at ABC could be a continuation of those injuries and not represent new injuries.

52. Dr. Schmidt agreed that any standing, walking, or weight-bearing activity would aggravate Petitioner's condition. Based on the condition shown in the emergency department x-rays of the right foot/ankle, "it would be extremely rare, if not unheard of, of someone to have that and not be symptomatic." When asked about footwear, Dr. Schmidt indicated he thought properly fitting work boots would be more beneficial than tennis shoes.

53. On redirect examination, Dr. Schmidt basically indicated one could not determine whether Petitioner's symptoms materially worsened after he started working for ABC Auto Auction.

54. On re-cross examination, Dr. Schmidt testified that calcification is indicative of the longstanding inflammation. He saw no medical records of Petitioner complaining of symptoms prior to November 6, 2013. He agreed that Petitioner's right foot was aggravated by his work for Speedco.

The Arbitrator found Petitioner's repetitive work activities for Speedco of standing, walking, bending kneeling, and stooping on concrete surfaces constituted compensable accidents. He noted that while simply walking and standing for extended periods of time are not "accidents" contemplated by the Act, "the Commission has repeatedly indicating (*sic*) that the amount and duration of walking done by a petitioner at work could constitute an increased risk of injury." Speedco argues that the Arbitrator erred in finding accident because the Commission has ruled that repetitive walking/standing in not an accident under the Act. It also argues that Petitioner exaggerated when reporting that he estimated he walked 10 miles a day at Speedco while Mr. Miller actually recorded the walking of crew chiefs and they walked between 1.5 and three miles a day.

Speedco is correct that the Commission has held that repetitive walking/standing does not constitute an accident contemplated under the Act. In *Cady v. State of Illinois – Menard Correctional Center*, 13 I.W.C.C. 981, the Commission wrote "there is no dispute that the basis of Petitioner's theory for recovery is the requirement of her job that she must stand and walk for extended periods of time. There is also no dispute that Petitioner did not suffer any acute trauma and could not attribute her condition to any specific event. Simply stated, the Commission does not believe that the mere act of 'repetitive standing' or 'repetitive walking' constitutes an accident as contemplated under the Workers' Compensation Act."

Similarly, in the claim now before the Commission, the basis for establishing compensable accidents is Petitioner's alleged repetitive standing and walking on hard surfaces. For an activity to be a compensable accident it must be something that is particularly associated with the claimant's particular work and not simply activities members of the general public encounter on a daily, if not hourly basis. The activities of walking and standing, even on hard surfaces, are activities that members of the public engage in continually in both work and non-work circumstances alike. Therefore, the Commission finds that Petitioner did not sustain his burden of proving he suffered compensable accidents.

The Commission also notes that in the *Cady* case cited above, like the Petitioner herein, the claimant's condition of ill-being was Achilles tendonitis and there the Commission found that the claimant did not prove causation as well as not proving a compensable accident. While the Commission predicates its decision principally on the finding that Petitioner did not prove compensable accidents, the Commission also finds that Petitioner did not sustain his burden of proving that his activities at work actually caused his condition of ill-being.

17IWCC0019

The Arbitrator was correct that Dr. Schmidt testified that the activities at work exacerbated his preexisting condition and Dr. Krause acknowledged that the activities likely increased his symptomology. However, the coincidence of symptoms while working alone does not establish that the working activities legally caused the condition that elicited the symptoms. Both Dr. Krause and Dr. Schmidt opined that the objective evidence of the extent of the calcification indicated that the disease process was longstanding. Even Dr. Mall acknowledged that Petitioner's condition was not "acute" in nature. In addition, Dr. Schmidt opined that any activity of everyday living would aggravate Petitioner's symptomology and Dr. Krause opined that the work activities did not change the natural progression of Petitioner's pre-existing ongoing disease. Finally, Dr. Mall admitted that Petitioner's work activities did not cause Petitioner's underlying condition and the only basis of opining causation was the coincidence of symptoms to work activities, which the Commission noted is not in itself sufficient to establish legal causation. In addition, Dr. Mall based his opinion on the history provided by Petitioner that he walked 10 miles a day, a history which was successfully rebutted by Respondent's witness.

Because the Commission finds that Petitioner neither sustained his burden of proving his work activities constituted compensable accidents nor sustained his burden of proving the work activities caused his condition of ill-being, compensation is denied. Accordingly, the Arbitrator's award of temporary total disability benefits, current and prospective medical expenses, and penalties and fees are vacated.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 13, 2016 is hereby reversed and compensation is denied.

IT IS FURTHER ORDERED BY THE COMMISSION that the Arbitrator's award of temporary total disability benefits, current and prospective medical expenses, and penalties and fees are vacated.

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 19 2017
O-12/6/16
RWW/dw
046

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JAMES BURNS,

Petitioner,

17IWCC0020

vs.

NO: 14 WC 41044

SPEEDCO & ABC AUTO AUCTION,

Respondents.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by Respondent, Speedco, herein and notice given to all parties, the Commission, after considering the issues of accident, notice, causation, temporary total disability, penalties and fees, and medical expenses both current and prospective, and being advised of the facts and law, reverses the Decision of the Arbitrator, finds that Petitioner did not prove compensable accidents, and denies compensation.

By way of background, Petitioner filed three separate claims naming both Speedco and ABC Auto Auction as respondents. Petitioner alleged different accident dates but alleged injuries to the same parts of the body caused by "repetitive walking activities" in all claims. The three alleged accident dates were the date Petitioner sought treatment, the date he last worked for Speedco, and the date he last worked for ABC Auto Auction. The claims were consolidated and arbitrated together. The Arbitrator issued three separate decisions disposing of each claim individually. In 14 WC 41057 The Arbitrator found ABC Auction not liable because he found Speedco was liable in the other claims (14 WC 12387 and 14 WC 41044), based on his determination that Petitioner's alleged injuries arose out of work activities performed during his employment with Speedco. ABC Auction moved to dismiss the Petition of Review filed by Speedco, in 14 WC 41057. The Commission denied that motion. By separate decisions, the Commission also reverses the Decision of the Arbitrator in 14 WC 12387 and affirms the Decision of the Arbitrator in 14 WC 41057.

Findings of Fact and Conclusions of Law

1. Petitioner testified on November 6, 2013 and February 14, 2014 he was employed by Speedco and April 15, 2014 he was employed by ABC Auto Auction. At Speedco he changed oil, changed tires, and performed preventative maintenance on diesel trucks. He had worked full time for Speedco for about seven or eight years. In November 2013 he was crew chief at Speedco, and had been for two to three years. He was scheduled to work eight hours a day and was able to take lunch "sometimes," but "most of the time *** it was busy, couldn't do that." In the month prior to November 2013 Petitioner's job became harder because there were a lot of new people after "the whole crew quit."

2. Petitioner's job responsibilities "were to of course sell stuff to the drivers, check the guy that's in the pit which is downstairs, check his work to make sure he did his work right, check his grease fittings, torque his plugs, the oil pan plugs, check tires." Besides checking on the work of the downstairs-guy, Petitioner was supposed to check "the whole top of the truck," check all 18 tires, add air if needed, and change fuel filters.

3. At Speedco there were five bays; "plenty of times" he would be in charge of all of them. On days in which he was the only crew chief, he did "quite a bit" of walking and was on his "feet all day long, all day long." He would not be able to take lunch breaks on those occasions. He would have to walk downstairs for every truck that was serviced. "Sometimes you'd do ten, some days you'd do 20." He would also have to walk the length of the truck, and "check all the fittings" if there was a trailer attached.

4. Petitioner also testified that Respondent's job description indicating he was on his feet 90% of the time was accurate. He could sit only when there were no customers. "It was a weird place to work, some days you wouldn't do any trucks or a couple, some days you'd do 20 and you wouldn't have a chance to do anything, you know."

5. The floor was concrete and the stairs were metal; "it was a slippery place" with oil and grease. One reason they issued work boots was because they were slip resistant. Employees ordered the boots through the Speedco distributor. The handbook provided that employees had to wear boots approved by Speedco. He believed Speedco paid for the boots. Boots would last about six months because they would deteriorate due the oil, grease, and water, but Respondent would only replace them once every year. "When you first put on the boots they were all right but after, you know, after an hour or so they're terrible, they rubbed – they were just terrible boots." They fit snuggly at first, but then "they loosened up and it's like your feet were flopping around inside the boot."

6. Petitioner began to develop problems with his feet while working for Speedco. He first noticed a burning sensation in the back of the right foot; he could not bend it. He noticed the problem using stairs, and did not have the problem when in his street shoes.

7. Normally, his feet would feel better after resting at home. He reported the condition "the day it wouldn't quit hurting." In November 2013 he had to stop working because of his right foot; he couldn't walk, couldn't stand, and had to drag his foot while walking because he could not bend it. He went to a hospital emergency department on November 6, 2013. When Petitioner went for treatment for his right foot, he also had symptoms in the left foot, but the problem was primarily on the right.

8. Petitioner was referred to Dr. Scherer from the emergency department. He had not treated for his feet previously. Petitioner then testified he had treatment for his right foot when he was 18 or 19 after he "dropped a motorcycle" on it. However, that was by his toes and in a different part of his foot than where he was having current problems.

9. Petitioner also testified that it sounded correct that he told Dr. Scherer that he walked 10 miles a day. He did not "know if it was actually 10 miles, you know, but it felt like 10 miles." Dr. Scherer prescribed a Cam boot and physical therapy and took him off work. Dr. Scherer released him to return to work on around December 3, 2013. Petitioner had to do the same amount of walking upon his return. He believed he had new boots when he came back to work. Symptoms in his right foot were tolerable for about a week, but then it "started up again." Within "a month tops" from returning to work he developed problems with his left foot as well; same as the right but less intense.

10. Petitioner told the assistant manager about problems with the left foot. That conversation was prior to his leaving Speedco. He left Speedco on February 14, 2014 because he "couldn't do it anymore, it hurt too bad" in his feet and ankles. He was not treating at that time and had no other job lined up. Petitioner wanted treatment for his feet and that was about the time he talked to his lawyer.

11. Petitioner thought he began working for ABC Auto Auction about a month after leaving Speedco. He got the job because a friend of his was a friend of the manager. He explained to the manager that he might have to take some time off to see a doctor for his feet. He worked as a mechanic for ABC Auction and did not have to do the same amount of walking/standing than he did at Speedco; "instead of walking around a big giant truck" he was "walking around a little car on a lift." He was able to take breaks and had had an hour lunch every day.

12. At ABC Auto Auction, Petitioner job was to "repo cars, stuff like that, fix stuff that was wrong with them, and they'd go to the auction on Thursday." He did not wear the Speedco boots on this job, and never wore those boots after leaving Speedco. He wore boots like police wear and tennis shoes at ABC. The change in footwear and job activities helped his feet "tremendously." However, his symptoms never went away completely.

13. Petitioner saw Dr. Mall on April 18, 2014. He discussed with Dr. Mall his respective job activities with Speedco and ABC. He "guessed" the first time ABC was "told of this work injury" at Speedco was after he saw Dr. Mall. However, Petitioner also testified that the manager knew about his feet the day he started at ABC. Dr. Mall has prescribed orthotics, medication, and physical therapy. Petitioner had to stop working for ABC because he "couldn't do it; it hurt." He thought the condition was a continuation from the work at Speedco, but thought he should give the job with ABC a try.

14. In June 2014 he began working for Jerry's Tires, where he performs maintenance of cars. He does not have to wear boots and wears tennis shoes, which are pretty comfortable. There are no walking requirements at Jerry's and his feet felt "pretty good actually." His feet actually "didn't even bother" him for two months. However, he was still having problems with his feet.

15. Speedco sent Petitioner to Dr. Schmidt. He asked Petitioner about his job activities at Speedco, ABC, and Jerry's. It was Petitioner's understanding that Dr. Schmidt agreed with Dr. Mall's recommendation for prospective treatment. It was also his understanding that Respondent had sent an e-mail indicating they were going to authorize treatment for the right foot, but no treatment had been authorized.

16. ABC sent Petitioner to Dr. Krause. Petitioner told Dr. Krause about his work activities at Speedco and he thought he told him about the boots. Petitioner would not want to return to work with Speedco, because his feet hurt too much; there was no way he could walk around there like he used to. Petitioner was rear-ended in a motor vehicle accident on November 23, 2013 and received treatment for injuries sustained in the accident. However, he did not injure his feet in the motor vehicle accident.

17. On cross examination from Speedco, agreed that he testified it felt like he walked 10 miles, but he did not measure it and "it might have been an exaggeration" but "it was a lot." There was a cashier who wore a pedometer which indicated she walked 22 miles a day, so he "was kind of going by that." Petitioner did not inform Speedco about his alleged February 14, 2014 accident; he did not talk to anybody there after he left.

18. Petitioner also testified his condition varies. Some days he has no pain and some days he cannot walk. Petitioner testified he walked on concrete and asphalt at ABC. However, the workspace at ABC was much smaller than at Speedco and he wore comfortable shoes. Working on cars at ABC involved about the same squatting and crawling as his job with Speedco. Petitioner has not had treatment for his left foot.

19. In the motor vehicle accident he did not slam his "feet down" but he did slam his head against the roof and had a bruise on his chest from the seatbelt. Petitioner agreed that he worked over time almost every week while he was at Jerry's.

20. On redirect examination, Petitioner testified after he returned to work at Speedco in December 2013 until he left on February 14, 2014, he told his supervisor, Russ Oliver, about problems with his left foot. He did not tell him that his problems were related to his work. Petitioner testified that he was prescribed medication by Dr. Mall, but he developed chest pain, which was warned on the label. He threw them in the trash. He mostly takes Ibuprofen. Petitioner reiterated that he was having problems with both feet when he began working for ABC.

21. Sean Miller was called by Speedco, for which he works as general manager supervising employees. Prior to his current position, he worked as technician and crew chief, which was the same job Petitioner had in 2012 and 2013. Mr. Miller was a crew chief for three years. When asked how long a crew chief is standing the witness answered "maybe four hours tops." He actually put a pedometer on a crew chief. He walked one and a half miles on a slow day and three miles on a busy day. He did not think he ever walked 10 miles on any day he was crew chief. On an average day there is "maybe three hours of down time." Mr. Miller testified that during down time they "most likely cleaned the shop or whatever" because "nobody likes to sit around for three hours."

22. Mr. Miller also testified he had a conversation with Petitioner on his last day of work. He asked Petitioner why he was quitting and he responded "that he was just tired of Speedco and all the new guys and he was fed up and he quit." He made no comments about his feet. He prepared the termination form submitted into evidence.

23. On cross examination, Mr. Miller agreed that Russ Oliver is an assistant manager at Speedco. He had a "number of crew chiefs who left" in 2013. He had to stretch out the shifts of crew chiefs and he was not always on the same shift as Petitioner. He agreed that Petitioner was supervising new mechanics, that new employees required greater supervision, and that was a reason for his quitting. However, there was usually somebody downstairs training a new guy so the crew chief would not have to go up and down the stairs. He agreed with Speedco's description of the job of technician requires standing for 90% of the time. Standing could include walking.

24. On November 6, 2013, Petitioner executed an accident/illness report, in which he indicated he was "just doing normal duties at work, walking, standing, going up and down stairs on hard concrete floor wearing steel toed shoes." He experienced Achilles tendon pain. Petitioner marked both that the accident was work related and not work related because his claim was denied so he was unsure. There is also an attestation from Dr. Scherer that Petitioner was restricted to seated work only and was using a crutch and walking boot. He was released to full duty as of December 2, 2013.

25. On November 11, 2014, Dr. Mall, a board certified orthopedic surgeon with fellowships training in sports medicine and shoulder surgery, testified by deposition. He treats

injuries to the feet. He sees the type of condition Petitioner had, which is common among "runners and people who are on their feet quite a bit."

26. Dr. Mall first saw Petitioner on April 15, 2014 and he "could have been" referred by Petitioner's lawyer. He received a letter from the lawyer's office with accompanying records. Petitioner reported he started having pain in his ankles into his feet bilaterally. It got more and more severe and he sought treatment in November 2013. He was referred to Dr. Scherer by the emergency department for right-sided Achilles tendon pain. Petitioner reported to Dr. Scherer that he walked 10 miles per day on concrete in work boots. The symptoms and history were similar to that he gave to Dr. Mall, except that "both feet were kind of bothering him when he came to see" him.

27. Petitioner reported that at Speedco he worked eight hour days with minimal breaks and had some over time. He walked on concrete floors in work boots. His pain got better when he took some time off and returned when he came back to work. That told Dr. Mall "that there's something about his work that seems to be causing or contributing to his discomfort." He had started working for ABC which was somewhat easier, but he still had the pain and had to stop working there on April 1, 2014.

28. Petitioner complained of pain over the Achilles tendon on both heels with some pain over the plantar fascial insertion. His pain was worse on the first steps of the morning, improved after "he's kind of warmed up," and worsened by the end of the day after being on his feet for a long period of time. Petitioner's report of his activities is similar to those he sees in other patients with Achilles tendonitis. Runners who run on hard surfaces are particularly at risk.

29. Regarding Petitioner's experiencing symptoms, Dr. Mall focused on Petitioner's walking on concrete surfaces and on his feet for eight to 10 hours a day with minimal breaks. He also noted that poor shoes can be a factor in causing these symptoms. Running as a causative factor for Achilles tendonitis is "all over the literature." Studies have also shown being on one's feet for a prolonged period of time is a causative factor for plantar fasciitis symptoms. Dr. Mall explained "planter fasciitis and Achilles tendonitis are very similar processes, whether or not you have pain on the top part of the calcaneus or the bottom part of the calcaneus." Dr. Mall cited a study in the Journal of Bone & Joint Surgery, which he deemed probably the most rigorously vetted journal in the field.

30. In looking at the coincidence of Petitioner's work and his symptoms Dr. Mall opined that "clearly it was coming from his work." "That's when he started denoting the symptoms, and, again, when he stopped working and then felt better and then went back to work and then it came back again." Petitioner had no other activities that would cause a risk factor for the condition. Dr. Mall explained that a person can have Achilles tendonitis demonstrable on MRI and not have any symptoms.

31. On examination, Petitioner exhibited signs of Achilles tendonitis and plantar fasciitis. However, he did not note any redness or dramatic deformity in the heels, though he may have had some swelling. X-rays showed some small calcified densities in the Achilles tendon insertion bilaterally, which was another indication of Achilles tendonitis. Dr. Mall also believed Petitioner had some plantar fasciitis as well, especially on the left. Dr. Mall recommended conservative treatment including splints, physical therapy, anti-inflammatories, and better footwear or orthotics. Dr. Mall did not believe any treatment had been authorized and that Petitioner had not been able to start physical therapy. He believed Petitioner had some stomach issues with the anti-inflammatories and had to stop them. Dr. Mall seemed to indicate that even though his work activities at ABC were lighter, his condition worsened due to lack of physical therapy.

32. Currently, Dr. Mall recommended custom shoe inserts. Topical gel and the use of tennis shoes had not worked for him. If Petitioner's condition continued to be sufficiently debilitating, he would consider surgery. The exact nature of the surgery would depend on MRI findings. Dr. Mall has not yet recommended surgery, and just began the conversation with Petitioner. There are also additional conservative treatment modalities that could be used. He would start with physical therapy.

33. Dr. Mall expected that if further treatment was not approved, Petitioner would continue to have symptoms. Dr. Mall was concerned that Petitioner was getting to the point that they would have to consider "kind of an escalation of treatment," because he had been persistently symptomatic for about six months.

34. Dr. Mall reviewed the report of Dr. Schmidt, Speedco's Section 12 medical examiner. He diagnosed retrocalcaneal bursitis. Dr. Mall is familiar with that diagnosis. He explained that "the retrocalcaneal bursitis is basically overlying the Achilles tendon. It's basically the same thing. To really be able to say one versus the other you'd probably have to get the MRI to see where the issues are coming from." The symptoms for the conditions are almost identical and the conservative treatment would be the same. Dr. Mall also noted that he did not see that Dr. Schmidt reviewed the x-rays which "would probably let him change that diagnosis to Achilles tendonitis" because it showed the calcium deposits. He agreed with Dr. Schmidt's opinion that Petitioner's condition was caused by his work as a crew chief for Speedo.

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38. Dr. Mall denied that he stated that Petitioner's work for Speedco was the cause of his condition. He said "that his symptoms initiated when he was working for Speedco. That's when his symptoms started, and they have never completely resolved." It was possible that he was still walking on concrete and continuing to aggravate his condition. However, he also did not receive the treatment Dr. Mall prescribed.

39. On May 5, 2015, Dr. Krause examined Petitioner at the request of ABC Auto Auction and issued a report pursuant to Section 12 of the Act. Petitioner reported working at Speedco in 2013 as crew chief. In June 2013 many people quit and he was required to do a lot more walking on both flat surfaces and up/down stairs. He started getting pain in his heels while working which became much worse in November 2013. On November 6, 2013 he went to the emergency department at Anderson Hospital. Dr. Krause then summarized treatment and other documentation.

40. Petitioner reported he was no longer working at Speedco but was then at Jerry's Tires. He had no physical therapy and essentially no conservative treatment. He gets pain bilaterally, worse on the right. Dr. Krause's exam appears to have been normal. Dr. Krause reviewed x-rays and MRIs. After his review of the record, tests, and examination, Dr. Krause diagnosed bilateral insertional calcific Achilles tendonitis with no evidence of plantar fasciitis. He then answered interrogatories.

41. Dr. Krause opined that the Achilles tendonitis predated the accident date of November 6, 2013. He agreed with Dr. Schmidt that the work activities at Speedco/ABC were not causally related to his chronic tendonitis. He noted that Dr. Mall was correct that symptoms of Achilles tendonitis wax and wane over time but he found "odd" that Petitioner did not have symptoms prior to November 6, 2013, but just because the symptoms while working did not mean the activities caused the condition.

42. Dr. Krause indicated that Petitioner's activities at Speedco would have exacerbated his "preexisting insertional Achilles tendonitis but it did not change the natural history of the disease process." Dr. Krause opined that Petitioner was at maximum medical improvement from his presumed injury of November 6, 2013, and could return to work with no restrictions.

43. Dr. Schmidt testified by deposition on August 12, 2015. He was been a board certified orthopedic surgeon for 18 years. He restricts his practice to treatment of the foot and ankle, performing between 300 and 450 surgeries annually. He has treated patients with Achilles tendonitis, retrocalcaneal bursitis, and plantar fasciitis. He explained that retrocalcaneal bursitis is an inflammation of the retrocalcaneal bursa, insertional Achilles tendonitis is an inflammation of the tendon as it inserts into the bone, and plantar fasciitis typically is inflammation of the ligament in the area where it hooks into the heel bone.

44. At the request of Speedco, he saw Petitioner twice for Section 12 medical examinations, the first time on July 24, 2014. Petitioner reported the gradual onset of bilateral ankle pain starting around November 6, 2013, "he attributed to repetitive walking, climbing, kneeling steel-toed boots and concrete floors." He felt his job changes because of new hires which increased his activities. By November 6, 2013 his right foot swelled and he had difficulty walking. He sought medical treatment at that time. He quit his job because of his ankle pain and the multiple new hires. Petitioner went to ABC Auction and he felt he lasted there about three months; he did not tolerate that job well because of his ankles. He then went to Jerry's Tires, which felt was better for him.

45. Dr. Schmidt's examination of Petitioner was relatively normal, except for tenderness in the retrocalcaneal area. The posterior tibial nerve and tendon, the Achilles tendon, and the calcaneal tuberosity were normal. These are areas associated with ankle/heel pain. Based on Petitioner's report of "a quantum leap in his activities," Dr. Schmidt felt his developing retrocalcaneal bursitis was a distinct possibility. He outlined conservative treatment which he deemed would be of benefit to Petitioner.

46. Dr. Schmidt saw Petitioner again on January 29, 2015. At this time he was provided medical records, which he was not provided prior to the initial examination. He saw an x-ray report of the right foot from the emergency department which indicated chronic Achilles tendonitis and a Haglund's deformity. Dr. Schmidt noted that "people with a Haglund's deformity have a high propensity of Achilles tendonitis." Petitioner then went to Dr. Scherer who prescribed conservative treatment for a diagnosis of acute Achilles tendonitis. Dr. Scherer also noted heterotrophic calcification, which forms over a long period of time and suggests chronic inflammatory change.

47. Dr. Schmidt also reviewed the records of Dr. Mall. Dr. Mall mentioned plantar fasciitis. However, Dr. Schmidt did not find that condition when he examined Petitioner on January 29, 2015. He took x-rays at that time, which showed the Haglund's deformity

and calcific deposits bilaterally. With a bilateral condition "basically it's more common is systemic type situation as opposed to a trauma situation." Dr. Schmidt concluded that Petitioner had bilateral calcific tendonitis, which he did not think was caused by his increased work load while working for Speedco, or his work activities at all. Petitioner would have intermittent flare-ups of his Achilles tendonitis and it would be exacerbated by any standing or walking.

48. Dr. Schmidt did not believe Petitioner was a surgical candidate. "It's a very difficult operation as far as recovery goes," and should be reserved "for rather extreme case and rather debilitating cases." Petitioner was actually functioning quite well. He was shown the MRI report showing 20% and 10% of the Achilles tendons. Dr. Schmidt indicated typically they would not intervene surgically with less than a 50% tear.

49. On cross examination, Dr. Schmidt agreed that Petitioner has right-sided calcified Achilles tendonitis, insertional tendonitis, and retrocalcaneal bursitis. He also agreed that those conditions are aggravated by activities and Petitioner first noted symptoms following work activities at Speedco. Petitioner was still complaining of symptoms when he last saw him on January 29, 2015 and reported no resolution of his symptoms. Dr. Schmidt believed the treatment he recommended in July 2014 would have still been beneficial as of January 29, 2015. He was not aware of any treatment being approved during that period.

50. Hypothetically, if Petitioner had left-sided symptoms while working at Speedco, the activities there would have aggravated his symptoms. He believed that currently Petitioner had the same conditions in his left foot/ankle as he did not the right. It was possible that Petitioner's left foot condition deteriorated when he went back to work for Speedco from December 2013 to February 2014.

51. Dr. Schmidt agreed that he indicated in his report that once a person develops the symptoms Petitioner had it would take a while to resolve them. He also agreed that if Petitioner suffered injuries to his ankles at Speedco, subsequent symptoms while working at ABC could be a continuation of those injuries and not represent new injuries.

52. Dr. Schmidt agreed that any standing, walking, or weight-bearing activity would aggravate Petitioner's condition. Based on the condition shown in the emergency department x-rays of the right foot/ankle, "it would be extremely rare, if not unheard of, of someone to have that and not be symptomatic." When asked about footwear, Dr. Schmidt indicated he thought properly fitting work boots would be more beneficial than tennis shoes.

53. On redirect examination, Dr. Schmidt basically indicated one could not determine whether Petitioner's symptoms materially worsened after he started working for ABC Auto Auction.

54. On re-cross examination, Dr. Schmidt testified that calcification is indicative of the longstanding inflammation. He saw no medical records of Petitioner complaining of symptoms prior to November 6, 2013. He agreed that Petitioner's right foot was aggravated by his work for Speedco.

The Arbitrator found Petitioner's repetitive work activities for Speedco of standing, walking, bending kneeling, and stooping on concrete surfaces constituted compensable accidents. He noted that while simply walking and standing for extended periods of time are not "accidents" contemplated by the Act, "the Commission has repeatedly indicating (*sic*) that the amount and duration of walking done by a petitioner at work could constitute an increased risk of injury." Speedco argues that the Arbitrator erred in finding accident because the Commission has ruled that repetitive walking/standing in not an accident under the Act. It also argues that Petitioner exaggerated when reporting that he estimated he walked 10 miles a day at Speedco while Mr. Miller actually recorded the walking of crew chiefs and they walked between 1.5 and three miles a day.

Speedco is correct that the Commission has held that repetitive walking/standing does not constitute an accident contemplated under the Act. In *Cady v. State of Illinois – Menard Correctional Center*, 13 I.W.C.C. 981, the Commission wrote "there is no dispute that the basis of Petitioner's theory for recovery is the requirement of her job that she must stand and walk for extended periods of time. There is also no dispute that Petitioner did not suffer any acute trauma and could not attribute her condition to any specific event. Simply stated, the Commission does not believe that the mere act of 'repetitive standing' or 'repetitive walking' constitutes an accident as contemplated under the Workers' Compensation Act."

Similarly, in the claim now before the Commission, the basis for establishing compensable accidents is Petitioner's alleged repetitive standing and walking on hard surfaces. For an activity to be a compensable accident it must be something that is particularly associated with the claimant's particular work and not simply activities members of the general public encounter on a daily, if not hourly basis. The activities of walking and standing, even on hard surfaces, are activities that members of the public engage in continually in both work and non-work circumstances alike. Therefore, the Commission finds that Petitioner did not sustain his burden of proving he suffered compensable accidents.

The Commission also notes that in the *Cady* case cited above, like the Petitioner herein, the claimant's condition of ill-being was Achilles tendonitis and there the Commission found that the claimant did not prove causation as well as not proving a compensable accident. While the Commission predicates its decision principally on the finding that Petitioner did not prove compensable accidents, the Commission also finds that Petitioner did not sustain his burden of proving that his activities at work actually caused his condition of ill-being.

17IWCC0020

The Arbitrator was correct that Dr. Schmidt testified that the activities at work exacerbated his preexisting condition and Dr. Krause acknowledged that the activities likely increased his symptomology. However, the coincidence of symptoms while working alone does not establish that the working activities legally caused the condition that elicited the symptoms. Both Dr. Krause and Dr. Schmidt opined that the objective evidence of the extent of the calcification indicated that the disease process was longstanding. Even Dr. Mall acknowledged that Petitioner's condition was not "acute" in nature. In addition, Dr. Schmidt opined that any activity of everyday living would aggravate Petitioner's symptomology and Dr. Krause opined that the work activities did not change the natural progression of Petitioner's pre-existing ongoing disease. Finally, Dr. Mall admitted that Petitioner's work activities did not cause Petitioner's underlying condition and the only basis of opining causation was the coincidence of symptoms to work activities, which the Commission noted is not in itself sufficient to establish legal causation. In addition, Dr. Mall based his opinion on the history provided by Petitioner that he walked 10 miles a day, a history which was successfully rebutted by Respondent's witness.

Because the Commission finds that Petitioner neither sustained his burden of proving his work activities constituted compensable accidents nor sustained his burden of proving the work activities caused his condition of ill-being, compensation is denied. Accordingly, the Arbitrator's award of temporary total disability benefits, current and prospective medical expenses, and penalties and fees are vacated.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 13, 2016 is hereby reversed and compensation is denied.

IT IS FURTHER ORDERED BY THE COMMISSION that the Arbitrator's award of temporary total disability benefits, current and prospective medical expenses, and penalties and fees are vacated.

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 19 2017
O-12/6/16
RWW/dw
046

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JAMES BURNS,

Petitioner,

17IWCC0021

vs.

NO: 14 WC 41057

SPEEDCO & ABC AUTO AUCTION,

Respondents.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by Respondent, Speedco, herein and notice given to all parties, the Commission, after considering the issues of accident, notice, causation, temporary total disability, penalties and fees, and medical expenses both current and prospective, and being advised of the facts and law, reverses the Decision of the Arbitrator, finds that Petitioner did not prove compensable accidents, and denies compensation.

By way of background, Petitioner filed three separate claims naming both Speedco and ABC Auto Auction as respondents. Petitioner alleged different accident dates but alleged injuries to the same parts of the body caused by "repetitive walking activities" in all claims. The three alleged accident dates were the date Petitioner sought treatment, the date he last worked for Speedco, and the date he last worked for ABC Auto Auction. The claims were consolidated and arbitrated together. The Arbitrator issued three separate decisions disposing of each claim individually. In this claim the Arbitrator found ABC Auction not liable because he found Speedco was liable in the other claims (14 WC 12387 and 14 WC 41044), based on his determination that Petitioner's alleged injuries arose out of work activities performed during his employment with Speedco. ABC Auction moved to dismiss the Petition of Review filed by Speedco, in the instant claim. The Commission denied that motion. By separate decisions, the Commission also reverses the Decisions of the Arbitrator in 14 WC 12387 and 14 WC 41044 and denies compensation in those claims.

Findings of Fact and Conclusions of Law

1. Petitioner testified on November 6, 2013 and February 14, 2014 he was employed by Speedco and April 15, 2014 he was employed by ABC Auto Auction. At Speedco he changed oil, changed tires, and performed preventative maintenance on diesel trucks. He had worked full time for Speedco for about seven or eight years. In November 2013 he was crew chief at Speedco, and had been for two to three years. He was scheduled to work eight hours a day and was able to take lunch "sometimes," but "most of the time *** it was busy, couldn't do that." In the month prior to November 2013 Petitioner's job became harder because there were a lot of new people after "the whole crew quit."

2. Petitioner's job responsibilities "were to of course sell stuff to the drivers, check the guy that's in the pit which is downstairs, check his work to make sure he did his work right, check his grease fittings, torque his plugs, the oil pan plugs, check tires." Besides checking on the work of the downstairs-guy, Petitioner was supposed to check "the whole top of the truck," check all 18 tires, add air if needed, and change fuel filters.

3. At Speedco there were five bays; "plenty of times" he would be in charge of all of them. On days in which he was the only crew chief, he did "quite a bit" of walking and was on his "feet all day long, all day long." He would not be able to take lunch breaks on those occasions. He would have to walk downstairs for every truck that was serviced. "Sometimes you'd do ten, some days you'd do 20." He would also have to walk the length of the truck, and "check all the fittings" if there was a trailer attached.

4. Petitioner also testified that Respondent's job description indicating he was on his feet 90% of the time was accurate. He could only sit when there were no customers. "It was a weird place to work, some days you wouldn't do any trucks or a couple, some days you'd do 20 and you wouldn't have a chance to do anything, you know."

5. The floor was concrete and the stairs were metal; "it was a slippery place" with oil and grease. One reason they issued work boots was because they were slip resistant. Employees ordered the boots through the Speedco distributor. The handbook provided that employees had to wear boots approved by Speedco. He believed Speedco paid for the boots. Boots would last about six months because they would deteriorate due the oil, grease, and water, but Respondent would only replace them once every year. "When you first put on the boots they were all right but after, you know, after an hour or so they're terrible, they rubbed – they were just terrible boots." They fit snuggly at first, but then "they loosened up and it's like your feet were flopping around inside the boot."

6. Petitioner began to develop problems with his feet while working for Speedco. He first noticed a burning sensation in the back of the right foot; he could not bend it. He noticed the problem using stairs, and did not have the problem when in his street shoes.

7. Normally, his feet would feel better after resting at home. He reported the condition "the day it wouldn't quit hurting." In November 2013 he had to stop working because of his right foot; he couldn't walk, couldn't stand, and had to drag his foot while walking because he could not bend it. He went to a hospital emergency department on November 6, 2013. When Petitioner went for treatment for his right foot, he also had symptoms in the left foot, but the problem was primarily on the right.

8. Petitioner was referred to Dr. Scherer from the emergency department. He had not treated for his feet previously. Petitioner then testified he had treatment for his right foot when he was 18 or 19 after he "dropped a motorcycle" on it. However, that was by his toes and in a different part of his foot than where he was having current problems.

9. Petitioner also testified that it sounded correct that he told Dr. Scherer that he walked 10 miles a day. He did not "know if it was actually 10 miles, you know, but it felt like 10 miles." Dr. Scherer prescribed a Cam boot and physical therapy and took him off work. Dr. Scherer released him to return to work on around December 3, 2013. Petitioner had to do the same amount of walking upon his return. He believed he had new boots when he came back to work. Symptoms in his right foot were tolerable for about a week, but then it "started up again." Within "a month tops" from returning to work he developed problems with his left foot as well; same as the right but less intense.

10. Petitioner told the assistant manager about problems with the left foot. That conversation was prior to his leaving Speedco. He left Speedco on February 14, 2014 because he "couldn't do it anymore, it hurt too bad" in his feet and ankles. He was not treating at that time and had no other job lined up. Petitioner wanted treatment for his feet and that was about the time he talked to his lawyer.

11. Petitioner thought he began working for ABC Auto Auction about a month after leaving Speedco. He got the job because a friend of his was a friend of the manager. He explained to the manager that he might have to take some time off to see a doctor for his feet. He worked as a mechanic for ABC Auction and did not have to do the same amount of walking/standing than he did at Speedco; "instead of walking around a big giant truck" he was "walking around a little car on a lift." He was able to take breaks and had had an hour lunch every day.

12. At ABC Auto Auction, Petitioner job was to "repo cars, stuff like that, fix stuff that was wrong with them, and they'd go to the auction on Thursday." He did not wear the Speedco boots on this job, and never wore those boots after leaving Speedco. He wore boots like police wear and tennis shoes at ABC. The change in footwear and job activities helped his feet "tremendously." However, his symptoms never went away completely.

13. Petitioner saw Dr. Mall on April 18, 2014. He discussed with Dr. Mall his respective job activities with Speedco and ABC. He "guessed" the first time ABC was "told of this work injury" at Speedco was after he saw Dr. Mall. However, Petitioner also testified that the manager knew about his feet the day he started at ABC. Dr. Mall has prescribed orthotics, medication, and physical therapy. Petitioner had to stop working for ABC because he "couldn't do it; it hurt." He thought the condition was a continuation from the work at Speedco, but thought he should give the job with ABC a try.

14. In June 2014 he began working for Jerry's Tires, where he performs maintenance of cars. He does not have to wear boots and wears tennis shoes, which are pretty comfortable. There are no walking requirements at Jerry's and his feet felt "pretty good actually." His feet actually "didn't even bother" him for two months. However, he was still having problems with his feet.

15. Speedco sent Petitioner to Dr. Schmidt. He asked Petitioner about his job activities at Speedco, ABC, and Jerry's. It was Petitioner's understanding that Dr. Schmidt agreed with Dr. Mall's recommendation for prospective treatment. It was also his understanding that Respondent had sent an e-mail indicating they were going to authorize treatment for the right foot, but no treatment had been authorized.

16. ABC sent Petitioner to Dr. Krause. Petitioner told Dr. Krause about his work activities at Speedco and he thought he told him about the boots. Petitioner would not want to return to work with Speedco, because his feet hurt too much; there was no way he could walk around there like he used to. Petitioner was rear-ended in a motor vehicle accident on November 23, 2013 and received treatment for injuries sustained in the accident. However, he did not injure his feet in the motor vehicle accident.

17. On cross examination from Speedco, agreed that he testified it felt like he walked 10 miles, but he did not measure it and "it might have been an exaggeration" but "it was a lot." There was a cashier who wore a pedometer which indicated she walked 22 miles a day, so he "was kind of going by that." Petitioner did not inform Speedco about his alleged February 14, 2014 accident; he did not talk to anybody there after he left.

18. Petitioner also testified his condition varies. Some days he has no pain and some days he cannot walk. Petitioner testified he walked on concrete and asphalt at ABC. However, the workspace at ABC was much smaller than at Speedco and he wore comfortable shoes. Working on cars at ABC involved about the same squatting and crawling as his job with Speedco. Petitioner has not had treatment for his left foot.

19. In the motor vehicle accident he did not slam his "feet down" but he did slam his head against the roof and had a bruise on his chest from the seatbelt. Petitioner agreed that he worked over time almost every week while he was at Jerry's.

20. On redirect examination, Petitioner testified after he returned to work at Speedco in December 2013 until he left on February 14, 2014, he told his supervisor, Russ Oliver, about problems with his left foot. He did not tell him that his problems were related to his work. Petitioner testified that he was prescribed medication by Dr. Mall, but he developed chest pain, which was warned on the label. He threw them in the trash. He mostly takes Ibuprofen. Petitioner reiterated that he was having problems with both feet when he began working for ABC.

21. Sean Miller was called by Speedco, for which he works as general manager supervising employees. Prior to his current position, he worked as technician and crew chief, which was the same job Petitioner had in 2012 and 2013. Mr. Miller was a crew chief for three years. When asked how long a crew chief is standing the witness answered "maybe four hours tops." He actually put a pedometer on a crew chief. He walked one and a half miles on a slow day and three miles on a busy day. He did not think he ever walked 10 miles on any day he was crew chief. On an average day there is "maybe three hours of down time." Mr. Miller testified that during down time they "most likely cleaned the shop or whatever" because "nobody likes to sit around for three hours."

22. Mr. Miller also testified he had a conversation with Petitioner on his last day of work. He asked Petitioner why he was quitting and he responded "that he was just tired of Speedco and all the new guys and he was fed up and he quit." He made no comments about his feet. He prepared the termination form submitted into evidence.

23. On cross examination, Mr. Miller agreed that Russ Oliver is an assistant manager at Speedco. He had a "number of crew chiefs who left" in 2013. He had to stretch out the shifts of crew chiefs and he was not always on the same shift as Petitioner. He agreed that Petitioner was supervising new mechanics, that new employees required greater supervision, and that was a reason for his quitting. However, there was usually somebody downstairs training a new guy so the crew chief would not have to go up and down the stairs. He agreed with Speedco's description of the job of technician requires standing for 90% of the time. Standing could include walking.

24. On November 6, 2013, Petitioner executed an accident/illness report, in which he indicated he was "just doing normal duties at work, walking, standing, going up and down stairs on hard concrete floor wearing steel toed shoes." He experienced Achilles tendon pain. Petitioner marked both that the accident was work related and not work related because his claim was denied so he was unsure. There is also an attestation from Dr. Scherer that Petitioner was restricted to seated work only and was using a crutch and walking boot. He was released to full duty as of December 2, 2013.

25. On November 11, 2014, Dr. Mall, a board certified orthopedic surgeon with fellowships training in sports medicine and shoulder surgery, testified by deposition. He treats

injuries to the feet. He sees the type of condition Petitioner had, which is common among "runners and people who are on their feet quite a bit."

26. Dr. Mall first saw Petitioner on April 15, 2014 and he "could have been" referred by Petitioner's lawyer. He received a letter from the lawyer's office with accompanying records. Petitioner reported he started having pain in his ankles into his feet bilaterally. It got more and more severe and he sought treatment in November 2013. He was referred to Dr. Scherer by the emergency department for right-sided Achilles tendon pain. Petitioner reported to Dr. Scherer that he walked 10 miles per day on concrete in work boots. The symptoms and history were similar to that he gave to Dr. Mall, except that "both feet were kind of bothering him when he came to see" him.

27. Petitioner reported that at Speedco he worked eight hour days with minimal breaks and had some over time. He walked on concrete floors in work boots. His pain got better when he took some time off and returned when he came back to work. That told Dr. Mall "that there's something about his work that seems to be causing or contributing to his discomfort." He had started working for ABC which was somewhat easier, but he still had the pain and had to stop working there on April 1, 2014.

28. Petitioner complained of pain over the Achilles tendon on both heels with some pain over the plantar fascial insertion. His pain was worse on the first steps of the morning, improved after "he's kind of warmed up," and worsened by the end of the day after being on his feet for a long period of time. Petitioner's report of his activities is similar to those he sees in other patients with Achilles tendonitis. Runners who run on hard surfaces are particularly at risk.

29. Regarding Petitioner's experiencing symptoms, Dr. Mall focused on Petitioner's walking on concrete surfaces and on his feet for eight to 10 hours a day with minimal breaks. He also noted that poor shoes can be a factor in causing these symptoms. Running as a causative factor for Achilles tendonitis is "all over the literature." Studies have also shown being on one's feet for a prolonged period of time is a causative factor for plantar fasciitis symptoms. Dr. Mall explained "planter fasciitis and Achilles tendonitis are very similar processes, whether or not you have pain on the top part of the calcaneus or the bottom part of the calcaneus." Dr. Mall cited a study in the Journal of Bone & Joint Surgery, which he deemed probably the most rigorously vetted journal in the field.

30. In looking at the coincidence of Petitioner's work and his symptoms Dr. Mall opined that "clearly it was coming from his work." "That's when he started denoting the symptoms, and, again, when he stopped working and then felt better and then went back to work and then it came back again." Petitioner had no other activities that would cause a risk factor for the condition. Dr. Mall explained that a person can have Achilles tendonitis demonstrable on MRI and not have any symptoms.

31. On examination, Petitioner exhibited signs of Achilles tendonitis and plantar fasciitis. However, he did not note any redness or dramatic deformity in the heels, though he may have had some swelling. X-rays showed some small calcified densities in the Achilles tendon insertion bilaterally, which was another indication of Achilles tendonitis. Dr. Mall also believed Petitioner had some plantar fasciitis as well, especially on the left. Dr. Mall recommended conservative treatment including splints, physical therapy, anti-inflammatories, and better footwear or orthotics. Dr. Mall did not believe any treatment had been authorized and that Petitioner had not been able to start physical therapy. He believed Petitioner had some stomach issues with the anti-inflammatories and had to stop them. Dr. Mall seemed to indicate that even though his work activities at ABC were lighter, his condition worsened due to lack of physical therapy.

32. Currently, Dr. Mall recommended custom shoe inserts. Topical gel and the use of tennis shoes had not worked for him. If Petitioner's condition continued to be sufficiently debilitating, he would consider surgery. The exact nature of the surgery would depend on MRI findings. Dr. Mall has not yet recommended surgery, and just began the conversation with Petitioner. There are also additional conservative treatment modalities that could be used. He would start with physical therapy.

33. Dr. Mall expected that if further treatment was not approved, Petitioner would continue to have symptoms. Dr. Mall was concerned that Petitioner was getting to the point that they would have to consider "kind of an escalation of treatment," because he had been persistently symptomatic for about six months.

34. Dr. Mall reviewed the report of Dr. Schmidt, Speedco's Section 12 medical examiner. He diagnosed retrocalcaneal bursitis. Dr. Mall is familiar with that diagnosis. He explained that "the retrocalcaneal bursitis is basically overlying the Achilles tendon. It's basically the same thing. To really be able to say one versus the other you'd probably have to get the MRI to see where the issues are coming from." The symptoms for the conditions are almost identical and the conservative treatment would be the same. Dr. Mall also noted that he did not see that Dr. Schmidt reviewed the x-rays which "would probably let him change that diagnosis to Achilles tendonitis" because it showed the calcium deposits. He agreed with Dr. Schmidt's opinion that Petitioner's condition was caused by his work as a crew chief for Speedo.

35. Dr. Mall also testified that Petitioner brought in the work boots he used at Speedco for 2&½ months; "the whole toe box was torn on both shoes. Both shoes had tearing on the back side of the heel area where the Achilles to kind of sitting." "The inner part of the boot was pretty beat up." He thought the boots were not "super high quality or at least that they are getting worn out in that 2&½ months, which is a pretty short period of time for the boots to look that bad." The condition of the boots "could potentially relate to some of his symptoms."

36. On cross examination, Dr. Mall testified that about 5% to 10% of his practice involved treatment of ankles. He agreed that Petitioner told him he walked approximately 10 miles a day. Petitioner also stated that a majority of the day he spent on his feet. Dr. Mall also agreed that the initial records mentioned only problems with his right foot. Nobody can really know how long it took to develop the conditions found by the radiologist in the x-rays taken at the emergency department. However, he agreed it was not an acute process.

37. Dr. Mall also testified that the lag in the onset of symptoms in the left foot could simply have developed after November 16, 2014 and when he left Speedco. Also, wearing a Cam boot can alter the patient's gait and cause symptoms on the other side. Differences in his specific treatment notes about symptoms can be attributable to the natural waxing/waning of symptoms.

38. Dr. Mall denied that he stated that Petitioner's work for Speedco was the cause of his condition. He said "that his symptoms initiated when he was working for Speedco. That's when his symptoms started, and they have never completely resolved." It was possible that he was still walking on concrete and continuing to aggravate his condition. However, he also did not receive the treatment Dr. Mall prescribed.

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42. Dr. Krause indicated that Petitioner's activities at Speedco would have exacerbated his "preexisting insertional Achilles tendonitis but it did not change the natural history of the disease process." Dr. Krause opined that Petitioner was at maximum medical improvement from his presumed injury of November 6, 2013, and could return to work with no restrictions.

43. Dr. Schmidt testified by deposition on August 12, 2015. He was been a board certified orthopedic surgeon for 18 years. He restricts his practice to treatment of the foot and ankle, performing between 300 and 450 surgeries annually. He has treated patients with Achilles tendonitis, retrocalcaneal bursitis, and plantar fasciitis. He explained that retrocalcaneal bursitis is an inflammation of the retrocalcaneal bursa, insertional Achilles tendonitis is an inflammation of the tendon as it inserts into the bone, and plantar fasciitis typically is inflammation of the ligament in the area where it hooks into the heel bone.

44. At the request of Speedco, he saw Petitioner twice for Section 12 medical examinations, the first time on July 24, 2014. Petitioner reported the gradual onset of bilateral ankle pain starting around November 6, 2013, "he attributed to repetitive walking, climbing, kneeling steel-toed boots and concrete floors." He felt his job changes because of new hires which increased his activities. By November 6, 2013 his right foot swelled and he had difficulty walking. He sought medical treatment at that time. He quit his job because of his ankle pain and the multiple new hires. Petitioner went to ABC Auction and he felt he lasted there about three months; he did not tolerate that job well because of his ankles. He then went to Jerry's Tires, which felt was better for him.

45. Dr. Schmidt's examination of Petitioner was relatively normal, except for tenderness in the retrocalcaneal area. The posterior tibial nerve and tendon, the Achilles tendon, and the calcaneal tuberosity were normal. These are areas associated with ankle/heel pain. Based on Petitioner's report of "a quantum leap in his activities," Dr. Schmidt felt his developing retrocalcaneal bursitis was a distinct possibility. He outlined conservative treatment which he deemed would be of benefit to Petitioner.

46. Dr. Schmidt saw Petitioner again on January 29, 2015. At this time he was provided medical records, which he was not provided prior to the initial examination. He saw an x-ray report of the right foot from the emergency department which indicated chronic Achilles tendonitis and a Haglund's deformity. Dr. Schmidt noted that "people with a Haglund's deformity have a high propensity of Achilles tendonitis." Petitioner then went to Dr. Scherer who prescribed conservative treatment for a diagnosis of acute Achilles tendonitis. Dr. Scherer also noted heterotrophic calcification, which forms over a long period of time and suggests chronic inflammatory change.

47. Dr. Schmidt also reviewed the records of Dr. Mall. Dr. Mall mentioned plantar fasciitis. However, Dr. Schmidt did not find that condition when he examined Petitioner on January 29, 2015. He took x-rays at that time, which showed the Haglund's deformity

and calcific deposits bilaterally. With a bilateral condition "basically it's more common is systemic type situation as opposed to a trauma situation." Dr. Schmidt concluded that Petitioner had bilateral calcific tendonitis, which he did not think was caused by his increased work load while working for Speedco, or his work activities at all. Petitioner would have intermittent flare-ups of his Achilles tendonitis and it would be exacerbated by any standing or walking.

48. Dr. Schmidt did not believe Petitioner was a surgical candidate. "It's a very difficult operation as far as recovery goes," and should be reserved "for rather extreme case and rather debilitating cases." Petitioner was actually functioning quite well. He was shown the MRI report showing 20% and 10% of the Achilles tendons. Dr. Schmidt indicated typically they would not intervene surgically with less than a 50% tear.

49. On cross examination, Dr. Schmidt agreed that Petitioner has right-sided calcified Achilles tendonitis, insertional tendonitis, and retrocalcaneal bursitis. He also agreed that those conditions are aggravated by activities and Petitioner first noted symptoms following work activities at Speedco. Petitioner was still complaining of symptoms when he last saw him on January 29, 2015 and reported no resolution of his symptoms. Dr. Schmidt believed the treatment he recommended in July 2014 would have still been beneficial as of January 29, 2015. He was not aware of any treatment being approved during that period.

50. Hypothetically, if Petitioner had left-sided symptoms while working at Speedco, the activities there would have aggravated his symptoms. He believed that currently Petitioner had the same conditions in his left foot/ankle as he did not the right. It was possible that Petitioner's left foot condition deteriorated when he went back to work for Speedco from December 2013 to February 2014.

51. Dr. Schmidt agreed that he indicated in his report that once a person develops the symptoms Petitioner had it would take a while to resolve them. He also agreed that if Petitioner suffered injuries to his ankles at Speedco, subsequent symptoms while working at ABC could be a continuation of those injuries and not represent new injuries.

52. Dr. Schmidt agreed that any standing, walking, or weight-bearing activity would aggravate Petitioner's condition. Based on the condition shown in the emergency department x-rays of the right foot/ankle, "it would be extremely rare, if not unheard of, of someone to have that and not be symptomatic." When asked about footwear, Dr. Schmidt indicated he thought properly fitting work boots would be more beneficial than tennis shoes.

53. On redirect examination, Dr. Schmidt basically indicated one could not determine whether Petitioner's symptoms materially worsened after he started working for ABC Auto Auction.

54. On re-cross examination, Dr. Schmidt testified that calcification is indicative of the longstanding inflammation. He saw no medical records of Petitioner complaining of symptoms prior to November 6, 2013. He agreed that Petitioner's right foot was aggravated by his work for Speedco.

In denying compensation in the instant claim, the Arbitrator found that Petitioner had not sustained an accident on April 15, 2014 and his condition of ill-being was not caused by his work activities with ABC Auto Auction. However, he also noted specifically, that "Petitioner's claim against this Employer is denied as Petitioner's condition of ill being had originated and was causally related to his employment with Speedco." He then cited the other claims. As noted above, the Commission agrees with the result of the Decision of the Arbitrator that Petitioner had not sustained his burden of proving accident or causation in this claim. However, also as noted above, by separate decisions the Commission reversed the Decision of the Arbitrator in the other claims and denied compensation. Therefore, the Arbitrator's finding that Petitioner sustained accidents in his employment with Speedco as a basis for denying compensation in this claim is deemed to be incorrect by the Commission.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 13, 2016 is hereby affirmed and compensation is denied.

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 19 2017
O-12/6/16
RWW/dw
046

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

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

Milton Mercado,
Petitioner,

vs. NO: 13 WC 32953

17IWCC0022

Weathershield Illinois, LIC,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issue(s) of temporary total disability, 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 November 2, 2015 is hereby affirmed and adopted.

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

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

17IWCC0022

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 $18,700.00. 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 19 2017

Joshua D. Luskin

o-01/18/17
jdl/wj
68

Charles J. DeVriendt

Ruth W. White

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

MERCADO, MILTON
Employee/Petitioner

Case# **13WC032953**

WEATHERSHIELD ILLINOIS LLC
Employer/Respondent

17IWCC0022

On 11/2/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.15% 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:

0147 CULLEN HASKINS NICHOLSON
PAT NICHOLSON
10 S WACKER DR SUITE 1760
CHICAGO, IL 60603

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

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
§ 19(b) ARBITRATION DECISION

Milton Mercado
Employee/Petitioner

Case # 13 WC 032953

v.

17IWCC0022

Weathershield Illinois, 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 **Steven Fruth**, Arbitrator of the Illinois Workers' Compensation Commission, in the city of Chicago, on **May 18, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **March 12, 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 **$ 34,536.32**; the average weekly wage was **$ 664.16.**

On the date of accident, Petitioner was **47** years of age, *married* with **no** 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 **$23,909.57** for TTD, **$0** for TPD, **$0** for maintenance, **$7,970.00** for PPD advance and **$0** for other benefits, for a total credit of **$31,879.57.**

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 **$442.77**/week for **111 & 1/7** weeks, commencing April 1, 2013 through May 18, 2015, as provided in § 8(b) of the Act.

Respondent shall be given a credit of **$31,879.57** for temporary total disability benefits and the permanent partial disability advance that have been paid.

Respondent shall pay reasonable and necessary medical services of **$1,289.97,** as provided in § 8(a) of the Act for prescription expenses incurred by Petitioner.

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of **$4,743.00** to **Dr. Akil Moinuddin** and **$1,597.00** to **Rush University Medical Center,** as provided in§ 8(a) and § 8.2 of the Act.

Respondent shall further authorize and pay for the prospective medical treatment recommended by Dr. Kern Singh and necessary follow-up medical care.

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

November 2, 2015
Date

NOV 2 - 2015

INTRODUCTION

This matter proceeded to hearing on May 18, 2015 before Arbitrator Steven Fruth. The disputed issues were: ***F:*** Is Petitioner's current condition of ill-being causally related to the accident?; ***J:*** Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?; ***K:*** What temporary benefits are in dispute? *TTD*; and ***O:*** Is Petitioner entitled to prospective medical care and services?

FINDINGS OF FACT

Petitioner was employed by Respondent as a caulker on March 12, 2013. Petitioner testified his job involved caulking commercial properties. To perform his duties, Petitioner used utility knives, five gallon buckets (weighed 70-80 lbs.) and up to a 40 ft. ladders (weighed about 70-100 lbs.).

Petitioner testified about mid-day on March 12, 2013 the ladder sunk into the muddy ground. When he attempted to pull the extended ladder from the mud, Petitioner testified he caught his foot and felt like he pulled a muscle in his low back. Petitioner testified he continued working for three to four days, but his condition did not improve. He was sent to the Fox Valley Walk-In Clinic (Fox Valley) by Eric, his supervisor.

Petitioner presented to Fox Valley on April 1, 2013. He complained of 8/10 low back pain. Physical examination revealed positive trigger points in the left lumbar spine but no vertebral tenderness. An x-ray showed mild to moderate degenerative disc disease. The examining physician recommended an orthopedic referral and that Petitioner avoid aggressive, physical activity until he saw an orthopedist. Norco and Medrol Dosepak were prescribed.

On April 6, 2013, Petitioner saw his primary care physician, Dr. Moinuddin, who prescribed pain medication.

Petitioner saw orthopedic surgeon Thomas McGivney at Castle Orthopedics & Sports medicine, S. C. on April 9, 2013 as a new patient. Petitioner gave a history of low back pain since lifting a ladder and getting stuck in mud on March 12, 2013. Petitioner also gave a history of a prior fusion at L3-5 with hardware in 2000. Hardware was subsequently removed. He marked a body diagram for areas of pain, including the left side of the neck, left fingers, right thoracic spine, lumbar spine, and the soles of his feet. Petitioner stated he had been doing well and working. Plain x-rays showed a solid fusion at L3-4 but the fusion at L4-5 was "questionable". Dr. McGivney's impression was low back pain with history of fusion and chronic back problems. Dr. McGivney recommended an MRI.

The lumbar MRI was obtained on April 23, 2013. The radiologist noted retrolisthesis of L2 on L3 with a mild annular tear with bulge at L2-3. There was moderately severe central canal stenosis also. L3-4 and L4-5 demonstrated the fusion. Changes at L5-S1 showed central cord stenosis and were suggestive of hypermobility. There was also fissuring at L1-2 with a small protrusion.

On April 26 Dr. McGivney found the MRI study demonstrated a disc protrusion and significant stenosis at L2-3, an annular tear with some acute and some degenerative changes, but no modic or

endplate changes to suggest chronicity. There is no indication of findings at the L5-S1 level. Dr. McGivney opined Petitioner may have sustained an injury to the L2-3 level "during work". He noted the L5-S1 segment was healthy due to being protected by the fusion. His diagnosis now included an L2-3 herniated disc.

Dr. McGivney discussed surgery, which Petitioner did not want. Dr. McGivney was not recommending surgery due to its difficulty and the lack of a guarantee petitioner would be able to return to work. He recommended therapy and a referral to Dr. Bathina for pain management.

Petitioner returned to Dr. McGivney on June 3, 2013. His pain was not improved. Petitioner had been to Dr. Bathina but declined the offer of injections. Dr. McGivney gave his authorization to increase physical therapy to 3 per week. He also encouraged Petitioner to accept the epidural injections.

Petitioner began a course of physical therapy at ATI in Aurora, 3 times a week. Dr. Bathina recommended an L2-3 transforaminal steroid injection which was done by Dr. Bathina on June 18, 2013. Petitioner testified that the injection gave him only temporary relief.

Petitioner last saw Dr. McGivney on July 8, 2013. Petitioner reported that he had one injection which gave 3-4 days of relief. Dr. McGivney noted that Petitioner had adjacent segment degeneration due to the fusion. A spinal stimulator was discussed. Dr. McGivney recommended completion of the series of epidural injections and that Petitioner seek a second opinion from Dr. Kern Singh about extending the fusion to L2-3.

Petitioner saw Dr. Singh of Midwest Orthopedics at Rush on August 7, 2013. Dr. Singh noted the prior L3 to L5 laminectomy and transforaminal lumbar interbody fusion. He noted that Petitioner's complaints were related to a workplace accident. He diagnosed adjacent-level disc degeneration at L2-3 with spinal stenosis and flat back syndrome. He performed an L2-L3 revision laminectomy with discectomy and L2-L3 fusion with PEEK cage and bone graft on August 20, 2013. He noted a solid fusion at L3-4 and L4-5.

When Petitioner returned to Dr. Singh for the 4-month post-operative follow-up he reported his condition was greatly improved and he experienced only occasional pain. Dr. Singh recommended Petitioner continue with physical therapy, and he released Petitioner to return to work with a 20 lbs. lifting restriction. At the 5-month post-operative visit on January 13, 2014, Petitioner reported occasional low back pain, numbness and tingling in both feet. Dr. Singh recommended a work conditioning program. Petitioner's restrictions remained the same.

Petitioner completed a Functional Capacity Evaluation on January 15, 2014. It was noted that the Petitioner was unable to squat and place weight on the floor during the floor to chair lift, with increased low back pain with squatting activities and pain levels increased during the rest of the day after that. Petitioner was rated at a medium physical demand level, but the therapist noted Petitioner needed to be at the heavy level in order to return to work. Dr. Singh recommended Petitioner complete the work conditioning program. Petitioner then began a period of work hardening at ATI which continued until March 14, 2014.

Petitioner testified that when attending physical therapy in February of 2014 he slipped on ice and fell. He testified that he landed flat on his tail bone. Petitioner testified he had pain and numbness when going to physical therapy that day.

At the 6-month post-operative follow-up with Dr. Singh on March 17, 2014 Petitioner reported significant relief overall and some low back pain prompted with waist bending and heavy lifting. Dr.

Singh released Petitioner to return to work at a light to medium physical demand level, per an FCE of March 9, 2014.

Petitioner admitted Respondent offered him an accommodated duty position, and he was initially scheduled to return to work on April 14, 2014. Petitioner admitted he did not return to work, as scheduled. He contacted Respondent and requested his return to work date be set for April 15, as he needed to be in court on April 14, 2014 for an automobile accident (occurred in August of 2013). Petitioner further admitted he never reported for work April 15.

Instead, Petitioner returned to Dr. Singh on April 21, 2014. He complained of low back and leg pain with numbness and tingling to the foot, prompted mostly by long periods of sitting, bending, and transitioning from sitting to standing. Petitioner reported difficulty performing his duties as cleared to perform per the FCE. Dr. Singh diagnosed a low back strain and recommended a CT scan along with no work. The CT scan on April 28, 2014 showed the instrumented l2-3 fusion, the solid osseous fusion and arthrodesis at L3-4 and L4-5, and also mild to moderate spinal canal and mild left foraminal narrowing at L2-3, as well as severe bilateral facet arthropathy with L5-S1 mild left foraminal narrowing.

Petitioner returned to Dr. Singh on April 28. Dr. Singh now noted Petitioner reported burning across the low back and right side after he threw his tool belt into his truck. Petitioner testified this occurred on April 14, 2014 when he threw his personal tools into his truck as he prepared to return to work. He complained of 7/10 pain. Dr. Singh noted the CT scan demonstrated a solid fusion at L2-3, L3-4, and L4-5 but also collapse of the disc space with moderate to severe spinal stenosis at L5-S1. Dr. Singh noted Petitioner had flat back syndrome from the prior L3-5 fusion and now required lordosis restoration to avoid adjacent level degeneration. He recommended an anterior L5-S1 fusion and laminectomy with instrumentation.

Dr. Steven Mather of DuPage Medical Group examined Petitioner pursuant to § 12 of the Act on August 28, 2014. When reviewing the MRI study from April 23, 2013, Dr. Mather noted the study demonstrated no foraminal stenosis at L5-S1 with plenty of fat around the nerve roots and the foramina. He noted some left L5-S1 subarticular stenosis affecting the left S1 root. The study also demonstrated a herniation at the L2-3. Dr. Mather noted that the April 28, 2014 CT scan showed the facet joints at L5-S1 were very arthritic and spondylitic, but no foraminal stenosis. He noted fat around the nerve roots at L5-S1 with every sagittal cut, and he noted Petitioner was fused in considerable flatback.

Based on a comparison of the April 2013 MRI to the April 2014 CT scan, Dr. Mather concluded the findings at the L5-S1 level were not causally related to the March 12, 2013 work injury. Dr. Mather noted there was no evidence of foraminal stenosis or disc collapse on the April 2013 study. He opined the study demonstrated a 100% healthy L5-S1 disc. He further opined the findings on the April 2014 CT scan study were therefore not related to the March 12, 2013 injury.

Dr. Mather further opined he disagreed with Dr. Singh's recommendation for surgery. Dr. Mather saw no evidence of nerve compression at the L5-S1 level. Instead, he opined Petitioner had flatback caused by the fusion performed in 2000 from L3 to L5. Dr. Mather noted that the only level with lordosis was at L2-3 where Dr. Singh performed the fusion. Dr. Mather therefore concluded Petitioner was at maximum medical improvement, required no further treatment, and could return to work with a 50 lbs. lifting restriction.

On December 5, 2014, Dr. Singh wrote a narrative report to Petitioner's counsel in which he noted that he had reviewed Dr. Mather's November 4, 2014 IME. He noted that Dr. Mather had

conducted a thorough exam and that he agreed with Dr. Mather's assessment of flat back syndrome and that there were degenerative changes at L5-S1. Dr. Singh opined that Petitioner's accelerated disc degeneration at L5-S1 was secondary to his flat back deformity and that the workplace injury mechanism was a competent cause for additional aggravation of an underlying degenerative condition. He further opined that the mechanism of injury was a causative factor in the symptoms becoming more present. He noted that Dr. Mather noted that there was no symptom magnification.

While he agreed with Dr. Mather's diagnosis, Dr. Singh continued with his opinion that a fusion at L5-S1 was necessary. Dr. Singh again opined that a fusion was the only way to restore the normal alignment of Petitioner's lumbar spine.

Petitioner last saw Dr. Singh on April 1, 2015. Petitioner continued to complain of 10/10 low back pain going down his legs. Dr. Singh again recommended the L5-S1 fusion.

Petitioner testified that he has not worked at any capacity since the accident of March 12, 2013. At the time of the hearing he continued to take Norco, ibuprofen and naproxen for his pain. Petitioner testified that he does not go out as much and is constantly in pain. It is hard to squat. When he gets up it is difficult to straighten up. When he carries something there is a sharp pain in his back. The medications he takes make him sleepy. He did admit to having the prior fusion and then the hardware removal in 2006, but that he was doing well after that surgery. He had his own lawn care business, but he stopped doing that after the March 12, 2013 accident.

Petitioner continued to see Dr. Moinuddin with complaints of the pain waking him up at night and that the pain had increased to severe low back pain.

He testified he wants to undergo the fusion at the L5-S1 level.

CONCLUSIONS OF LAW

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

The Arbitrator concludes that petitioner proved that his current condition of ill-belling is causally related to his workplace injury on March 12, 2013.

Petitioner must prove that his condition of ill-being is causally related to the work accident. However, a petitioner need only prove that the work accident was a causative factor in the condition of ill-being being related to the work accident. Here Petitioner has established by a chain of events that demonstrate a previous condition of relative good health after the prior fusion and subsequent hardware removal in 2006, an accident which is not disputed and a subsequent injury resulting in disability to establish a causal connection between the accident and the need for prospective surgery as recommended by Dr. Singh. There is no evidence that Petitioner had any treatment to his low back from the time he recovered from the fusion and hardware removal up until the date of his workplace accident on March 12, 2013.

The Arbitrator finds that Petitioner was a credible witness when describing his medical history and post-accident complaints. This assessment is bolstered by Dr. Mather's observation that Petitioner did not magnify his complaints during the IME.

It is undisputed that Petitioner had a previous L3, L4, L5 fusion, with subsequent hardware removal. It is undisputed that Petitioner had a lateral interbody fusion at L2-L3 that was necessary to cure or relieve an injury sustained in the workplace March 12, 2013. At issue are the competing

opinions of Petitioner's treating physician, Dr. Kern Singh, and Respondent's retained expert physician, Dr. Steven Mather.

Drs. Singh and Mather agree on Pettioner's base diagnosis of flat back syndrome along with degenerative L5-S1. Dr. Singh opines that Petitioner's current condition is causally related to the workplace accident. He believes that further surgery is necessary to relieve Pettioner's persistent back pain and limitations. He believes the surgery will return some degree of lordosis to Petitioner's lumbar spine. Dr. Mather opines that Pettioner's current condition is not causally related to the workplace accident. Dr. Mather further believes that surgery is not necessary to cure or relieve Petitioner's current medical problems.

Dr. Singh's causation opinion is based on his extensive care of Petitioner from August 2013 into 2015. Dr. Singh performed fusion surgery at L2-3 and supervised Petitioner's post-operative course. His opinions have the credibility of being on the scene throughout petitioner's care and treatment.

In light of all the evidence the Arbitrator finds that Dr. Singh's causation opinions are more persuasive than those of Dr. Mather. Dr. Singh had a much more extensive relationship with Petitioner than did Dr. Mather. The Arbitrator finds Dr. Singh explanation of causation by aggravation of an underlying degenerative condition to be reasonable. The Arbitrator takes note that Dr. Mather, as a retained expert, may have been more prone to bias or prejudice than the treating physician, whose goal is to cure or relieve the patient's complaints.

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

Billing for Dr. Moinuddin for care and treatment from April 6, 2013 to March 12, 2015 totals $4,743.00. Dr. Moinuddin assisted in managing Petitioner's pain with medications and blood testing provided during this time. Similarly, the prescriptions submitted by Petitioner and prescribed by Dr. Moinuddin in the amount of $1,289.97 cover approximately the same time period. There is no medical information submitted by Respondent that this treatment is not reasonable and necessary or not related to the accident. Dr. Mather did not comment regarding either the treatment or the charges by these providers. A significant portion of that billing relates to treatment during a time period within which Respondent accepted liability. Therefore, the Arbitrator awards Petitioner those charges, subject to the fee schedule.

The charge from Rush University Medical Center relates to pre-operative lab work and other testing done on April 30, 2014. The Arbitrator finds that the prospective medical that was requested by Petitioner is awarded as set forth below and therefore this billing is awarded to Petitioner in the amount of $1,597.00, subject to the fee schedule.

K: What temporary benefits are in dispute? ***TTD***

On March 17, 2014, Dr. Kern Singh released Petitioner to return to work within the restrictions outlined from the FCE. At that time Dr. Singh noted that Petitioner had constant low back pain with waist bending activity and heavy lifting and was taking medication of Norco, Flexeril and ibuprofen at that time. Petitioner saw Dr. Moinuddin on March 31, 2014 and complained of worsening back pain.

Respondent agreed to accommodate Petitioner's restrictions beginning on or about April 14, 2014. Petitioner testified that he intended to return to work when he was loading his tool belt into his truck in anticipation of doing so and he experienced increased back pain.

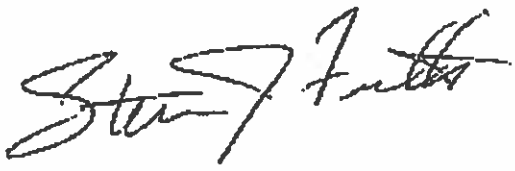
Petitioner returned to his treating physician, Dr. Singh, on April 21, 2014. Due to the nature of Petitioner's complaints and clinical presentation Dr.Singh took Petitioner off work. There was no evidence until Dr. Mather's IME on November 4, 2014 to suggest that Petitioner was capable of working after the April exacerbation. Dr. Mather opined that Petitioner could return to work with a 50 lb. lifting restriction. However, there is no evidence that Respondent offered to take the Petitioner back to work at that time within those restrictions.

In light of all the evidence the Arbitrator finds that Petitioner was able to prove that he was entitled to TTD benefits from April 1, 2013 to the date of the trial, May 18, 2015.

O: Is Petitioner entitled to prospective medical care and services?

The Arbitrator previously found the causation opinions of Petitioner's treating physician, Dr. Kern Singh, to be more persuasive than the causation opinions of Respondent's retained expert, Dr. Steven Mather. The Arbitrator, for reasons stated above, also finds Dr. Singh's opinion of the necessity of prospective surgery at L5-S1 is more persuasive than the opinion of Dr. Mather to contrary.

Based upon the foregoing, the Arbitrator finds that the prospective surgery recommended by Dr. Singh is causally related to Petitioner's workplace accident of March 12, 2013 and that petitioner was able to prove that the recommended surgery is reasonably necessary to cure or relieve Pettioner's condition of ill-being. Respondent is ordered to authorize and pay for the procedure as well as all necessary related post-operative medical care.



November 2, 2015

Steven J. Fruth, Arbitrator

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

Robert Frailey,
Petitioner,

vs.

NO: 12 WC 06699
12 WC 33153 consolidated case

KR Drenth Trucking, Inc.,
Respondent.

17IWCC0023

DECISION AND OPINION ON REVIEW

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

This claim proceeded to hearing pursuant to Sections 8(a) and 19(b) of the Act and the nature and extent of the injury was not placed in dispute. The Arbitrator acknowledged such at the hearing, and ordered prospective medical care, but did not overtly specify that an additional hearing for further benefits would be proper in the Order, so the Commission adds the following language to the Order section of the Arbitrator's Decision:

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.

All else is otherwise affirmed and adopted.

17IWCC0023

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 17, 2015 is hereby affirmed and adopted.

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $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 19 2017

Joshua D. Luskin

o-01/18/17
jdl/wj
68

Charles J. DeVriendt

Ruth W. White

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

FRAILEY, ROBERT
Employee/Petitioner

Case# **12WC006699**

12WC033153

KR DRENTH TRUCKING INC
Employer/Respondent

17IWCC0023

On 11/17/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.33% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0328 LEWIS & DAVIDSON LTD
ANN-LOUISE DAVIDSON
ONE N FRANKLIN ST SUITE 1850
CHICAGO, IL 60606

2965 KEEFE CAMPBELL BIERY & ASSOC
MATTHEW IGNOFFO
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
CORRECTED ARBITRATION DECISION

ROBER FRAILEY
Employee/Petitioner

v.

KR DRENTH TRUCKING, INC.
Employer/Respondent

Case # 12 WC 06699

Consolidated cases: 12 WC 33153

17IWCC0023

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Jessica A. Hegarty**, Arbitrator of the Commission, in Elgin, Illinois on **7-13-15**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings (with respect to 12 WC 06699) on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **9-4-10**, 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 **$48,824.00**; the average weekly wage was of **$697.70**.

On the date of accident, Petitioner was **49** years of age, ***married*** with **1** dependent children.

Petitioner ***has not*** received all reasonable and necessary medical services.

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

Respondent shall be given a credit of **$18,133.44** for TTD, **$N/A** for TPD, **$N/A** for maintenance, and **$N/A** for other benefits, for a total credit of **$N/A**.

Respondent is entitled to a credit of **$5,023.44** under Section 8(j) of the Act.

ORDER

Medical Bill(s)

- The Arbitrator finds that the Respondent is liable for the following medical bills:
  Dr. Panchal $900.00.
  Dr. Raju $547.44
  Dr. Cybulski $460.00

Prospective Medical

- Petitioner is entitled to prospective medical care, namely a C7-T1 anterior cervical discectomy and fusion.

TTD

- Petitioner in entitled to benefits from September 5, 2010, through June 2, 2011, a period of 38 and 5/7 weeks and from May 21, 2012,through the date of hearing, a period of 164-1/7 weeks.

- The Arbitrator concludes that Petitioner is entitled to compensation for 202-6/7 weeks of temporary total disability, subject to credit for payments made.

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

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

17IWCC0023

Signature of Arbitrator

11/9/15
Date

NOV 17 2015

STATE OF ILLINOIS)
)SS
COUNTY OF KANE)

17IWCC0023

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

ROBERT FRAILEY,
Petitioner,

v.

KR DRENTH TRUCKING,
Respondent.

Case No: **12 WC 6699** consolidated with 12 WC 33153

ADDENDUM TO THE DECISION OF ARBITRATOR

On July 13, 2015, this matter proceeded to hearing pursuant to Section 19(b) of the Illinois Workers' Compensation Act (the "Act") before Arbitrator Jessica A. Hegarty in Elgin, Illinois.

Petitioner filed two claims that were consolidated for trial. The Arbitrator has issued a separate decision for 12WC 33153.

The disputed issues with respect to 12 WC 6699 are:

- Causal connection
- Medical Bills
- TTD
- Prospective Medical Treatment

STATEMENT OF FACTS

Petitioner was employed with Respondent as a truck mechanic. (Tr. at 7). Respondent is in the business of hauling garbage and waste to landfills. (Id.). Petitioner testified he had to work until all jobs were completed and that overtime was mandatory. (Id. at 8).

On September 4, 2010, Petitioner was involved in an undisputed work accident while servicing a truck. As he stepped down off the truck, onto the truck's fuel tank, he lost his footing and fell five feet to the ground. He testified he landed on his right side and felt pain from his neck into his back, shoulder, and right arm into the fingertips. (Id.).

On September 4, 2010, Petitioner presented to Advocate Good Shepard Hospital with a history of falling 5 feet onto his back while at work. (PX#1). Complaints of shooting pain in the neck on the right side down to his right fifth finger were noted. (Id.). Petitioner underwent a CT of the lumbar spine which revealed no lumbar spine fractures,

alignment of the lumbar spine appeared anatomic with mild bulging at the L5-S1 disc. (Id.). A CT of the cervical spine revealed mild bulging of the C2-3, C3-4, C4-5, and C5-6 discs. (Id). The impression noted was fall, neck pain, and lower back pain. (Id.). He was to follow up with Dr. Kanu Panchal whom his wife worked for. (PX #1; Tr. at 13). On September 7, 2010, Petitioner signed a KRD Trucking Employee's Report of Injury regarding the September 4, 2010 incident. (Tr. at 50, RX #5 at 1-2).

On September 7, 2010, Petitioner presented to neurosurgeon Kanu Panchal, who noted a history of Petitioner falling off of a truck on September 4, 2010 and landing on his right arm and right buttock. (PX#2). Petitioner complained of neck stiffness and limitation of movement. There was tingling and numbness in the fingers of the right hand. (Id.). The impression was cervical radiculopathy and lower back pain. (Id.). A cervical MRI was recommended and therapy. Petitioner was to be off of work for a week. (Id.).

On September 8, 2010, a cervical MRI revealed focal right foraminal protrusion at C7-T1 with foraminal stenosis, which was moderate to severe. (PX #2, #3).

On September 10, 2010, Petitioner returned to Dr. Panchal complaining of severe intractable neck pain. The doctor noted the cervical MRI showed a moderately sized herniated disc at the level of C7-T1 on the right side. Petitioner was to be off work for three weeks. (PX #2).

On September 23, 2010, Petitioner followed up with Dr. Panchal with complaints of severe neck pain and scapular pain radiating into the right arm. He indicated physical therapy caused him extreme pain. Dr. Panchal diagnosed C8 radiculopathy on the right side due to a herniated disc at C7-T1. He recommended a posterior laminotomy at C7-T1 on the right side, an EMG/NCS for the right arm, and follow up the following week. Petitioner was to be off of work for a month. (Id.).

On September 29, 2010, Petitioner presented to Dr. Babak Lami, at Dr. Panchal's request for a second opinion (Tr. at 49). Dr. Lami diagnosed a traumatic disc herniation at C7-T1 with radiculopathy. He was in agreement with Dr. Panchel's proposed surgery. (Id.).

On November 19, 2010, Petitioner underwent a cervical laminotomy C7-T1 with removal of herniated disc at Northern Illinois Medical Center performed by Dr. Panchal. (Id.).

On November 29, 2010, Petitioner presented to Dr. Panchal who noted he was doing well. Radicular pain in the arm was gone although Petitioner did complain of weakness and numbness. A strengthening exercise program was recommended. Petitioner was to be off of work for six weeks. (Id.).

On January 3, 2011, Petitioner followed up with Dr. Panchal. Petitioner reported his right arm was weak. Dr. Panchal indicated Petitioner was doing well post laminotomy. He recommended continued physical therapy for three weeks, off work until February 15, 2011, and a follow up in three weeks. (Id.)

On January 24, 2011, Petitioner returned to Dr. Panchal who noted complaints of neck discomfort and right arm weakness. He was noted to be doing well. Therapy was to continue for a month and Petitioner would stay off work. (Id.)

Accelerated Rehabilitation notes dated January 24, 2011 indicate significant improvement and pain at its worst rated at 2 out of 10. (Id.).

On February 28, 2011, Petitioner followed up with Dr. Panchal. Petitioner complained of increasing neck pain. Dr. Panchal indicated Petitioner was doing well, though not fully recovered. He recommended continued PT for four weeks, off work for six weeks, and a follow up in six weeks. (Id.).

A discharge note from Accelerated Rehab dated March 29, 2011 indicates Petitioner had plateaued. Strength in the right upper extremity had improved. (PX #8 at 15).

On April 1, 2011, Petitioner presented for an IME with Dr. Babak Lami at Respondent's request. Petitioner stated the surgery helped him significantly and he no longer had radicular symptoms. Dr. Lami indicated Petitioner had recovered well from the surgery and had an excellent prognosis. He noted that all treatment had been appropriate and related. He indicated two to three weeks of work conditioning would be reasonable before a full duty release. He indicated Petitioner could return to full duty following the 2-3 weeks of work conditioning. (RX #11, Deposition Exhibit #2).

On April 11, 2011, Petitioner returned to Dr. Panchal complaining of neck pain and weakness in his arm. The radicular pain was mostly gone. Work hardening was recommended for four weeks. Petitioner was to be off work for six weeks. (PX #2).

As of May 11, 2011 Petitioner had attended 17 work conditioning sessions. Petitioner had good potential to obtain the goal of returning to work within the Heavy physical demand capacity level. (Id.).

On May 12, 2011, Petitioner followed up with Dr. Panchal. Petitioner complained of neck pain and right scapular pain. He denied tingling or numbness and there was no weakness on upper extremity exam. Dr. Panchal recommended continued work hardening for three more weeks, off work for six weeks and follow up after. (Id.).

A May 26, 2011 addendum report from Dr. Lami notes his review of Dr. Panchal's May 12, 2011 record where Petitioner had no weakness or radicular symptoms. He indicated Petitioner had reached MMI and could return to work without restrictions. (RX #11, Deposition Exhibit #3).

On June 3, 2011, Petitioner returned to regular duty work for Respondent. (Tr. at 24). Petitioner testified he was weak when he returned to work. (Tr. at 25). He testified that was assigned to grease a truck, but when he tried to squeeze the trigger of the grease gun, he could not make it work. He thought that perhaps it was a new gun with a safety switch on it and asked someone how to operate the switch. There was no switch; he did not have the strength to squeeze the trigger.

On June 30, 2011, Petitioner returned to Dr. Panchal complaining of pain in the right paraspinal area of the neck when doing heavy physical work. It is noted Petitioner had returned to regular duty work. The doctor noted he was doing well and could continue regular duty work. (PX #2.)

At his September 1, 2011, appointment Dr. Panchal noted the restricted and painful motion of his neck, weakness in his right hand grip and absent right triceps reflexes (p.24-26, PX2).

Through the fall of 2011, Petitioner testified he was experiencing increasing pain and weakness and, as a result, he was having trouble keeping up at work. He testified that on one occasion, when he grabbed a hammer, which was heavier than a regular hammer and more like a mallet, and went to swing it, it flew out of his hand. He needed two hands to have the strength to hang onto it, but he really had to have one hand free to hold the chisel he used with the hammer. Trying to balance the chisel while holding the hammer with two hands was awkward and made it difficult for him to do his job.

On October 14, 2011, an Employee Disciplinary Report was prepared by Joe Goodman regarding Petitioner not being able to complete a job timely. (Tr. at 82-83; RX #5 at 11). Petitioner testified he remembered this incident. (Tr. at 54). On cross examination Petitioner admitted this write up was in conflict with his previous testimony that he had to stay to the end of the day, or later, to complete job tasks. (Id.).

Mr. Goodman testified there is no mandatory overtime at KRD and no policy requiring overtime. (Tr. at 89-90).

On November 30, 2011, an Employee Disciplinary Report was prepared regarding substandard work and failure to follow instructions. (Tr. at 83, RX #5 at 12). Petitioner was suspended one day and signed the report on November 11, 2011. (Tr. at 56-57).

On December 12, 2011, Petitioner followed up with Dr. Panchal. Petitioner stated he was still feeling weakness in the right hand and neck pain. Neck movement was minimally restricted. Dr. Panchal diagnosed cervical radiculopathy on the right side. He recommended a cervical MRI and EMG/NCS of the right arm and follow up after. (PX #2).

Petitioner testified regarding a January 5, 2012 job task of replacing a fuel tank on a truck. (Tr. at 28). He testified he brought a fork lift alongside the truck to assist him in replacing the tank. (Tr. at 28-29). Petitioner testified he felt a pop in his neck and radiating pain into his hand when pushing the fuel tank into place. (Tr. at 29). He testified he told Joe Goodman. (Id.). Petitioner went home and took pain pills. (Tr. at 30).

Respondent witness Joe Goodman was working with Petitioner on January 5, 2012. (Tr. at 83). Mr. Goodman described the job task Petitioner was performing on this date of replacing a fuel tank. (Tr. at 84). Mr. Goodman was with Petitioner while he was performing this work. (Tr. at 84-85). He testified a fork lift could not be used to assist

Petitioner because where the truck was sitting you could not get a fork lift beside it. (Tr. at 85). Mr. Goodman testified Petitioner did not report any sort of pain or injury on January 5, 2012. (Tr. at 87).

When Petitioner returned to work he was told he had put bad fuel into the semi he was working on. (Tr. at 31). He was written up and fired as a result on January 6, 2012. (Tr. at 31, 86, RX #5 at 15). An Employee Disciplinary Report was prepared on January 6, 2012 by Joe Goodman regarding the contamination of fuel following the tank replacement and damage to an engine. (RX #5 at 15). On cross examination Petitioner admitted this report does not mention a January 5, 2012 injury. (Tr. at 60).

Petitioner testified he had his own tools that he worked with and used while working for Respondent. (Tr. at 47). When he left work on January 5 or 6, 2012 he took his tools with him. (Tr. at 48). The tools were kept in a tool box approximately three feet by two feet by two feet. (Id.). He testified the tool box weighed 500 pounds and he came and picked them up after he was terminated. (Tr. at 48-49).

Mr. Goodman also testified regarding Petitioner removing his tools after he was terminated. (Tr. at 87-88). Mr. Goodman indicated Petitioner did not appear to have any difficulty with removing the tools. (Tr. at 88). Mr. Goodman offered to help Petitioner and Petitioner refused. (Id.). On rebuttal, Petitioner testified he had friends, Mitch Gaskill and Dave Heller, assist him with the tool box. (Tr. at 94). Mr. Goodman was recalled and he testified it was not accurate that Mitch Gaskill and Dave Heller assisted Petitioner because there was no one present except Mr. Goodman and Petitioner when Petitioner took his tools. (Tr. at 95-96).

On January 9, 2012, Petitioner presented for a cervical MRI. (PX #2, #3). The impression indicates:

There is now evidence for postsurgical changes related to right C7 laminectomy and discectomy as discussed. No evidence for recurrent herniated disk fragments and no central canal or foraminal stenoses;

Stable appearance of mild to moderate fairly symmetric multilevel disk bulges from C3-4 through C6-7, but no significant central canal or foraminal stenoses.

On January 17, 2012, Petitioner presented for an electromyogram/nerve conduction study. The September 2010 work injury is noted. There is no reference to a January 2012 work injury. All nerve conduction studies were normal. The conclusion notes right chronic neurogenic changes in the right FDI suggestive of chronic injury from past cervical radiculopathy at C6-7; no acute findings; and consider physical therapy. (PX #2, RX #10 at 6).

On January 19, 2012, Petitioner followed up with Dr. Panchal. Petitioner stated he was feeling weakness in the right arm, but not much neck pain, or pain going down the arm. There is no mention of a January 5, 2012 alleged work injury in this record. Dr. Panchal indicated the MRI showed postoperative changes, but no compressive lesion. He

indicated he believed Petitioner's condition had plateaued and some weakness could be permanent. Petitioner was to follow up as necessary. (PX #2).

Petitioner testified he was feeling a little better by the time of this January 19, 2012 appointment. (Tr. at 32). Petitioner testified he did not tell Dr. Panchal what happened at work on January 5, 2012. (Tr. at 33, 61).

Petitioner testified he received unemployment benefits from January 22, 2012 through June 16, 2012. (Tr. at 62; See RX #9). Petitioner reported that he was ready, willing, and able to work for this time period and this is how he was able to get the unemployment benefits. (Tr. at 63).

On February 13, 2012, Petitioner followed up with Dr. Panchal. Petitioner stated that on January 5, 2012 he was at work lifting a heavy steel tank when suddenly he felt severe pain in the neck, right shoulder, and right arm. Dr. Panchal diagnosed cervical radiculopathy. He prescribed motrin, flexeril and noted a follow up in two weeks. (PX #2).

On February 24, 2012, an Application for Adjustment of Claim with case number 12 WC 6699 was filed alleging a date of accident "on or about" August 1, 2010. (RX #1). Petitioner testified he did not know why this injury date was alleged when the actual injury occurred on September 4, 2010. (Tr. at 66).

On February 27, 2012, Petitioner followed up with Dr. Panchal. Petitioner complained of neck pain radiating down the right arm. Dr. Panchal recommended an MRI of the cervical spine and a follow up after the MRI. (PX #2).

On April 26, 2012 Petitioner followed up with Dr. Panchal. Petitioner complained of neck and shoulder pain. Dr. Panchal diagnosed cervical radiculopathy. He recommended additional views of the cervical spine to detect instability and PT. (PX #5).
On May 24, 2012, Petitioner presented to Accelerated for an initial evaluation. The September 2010 work injury is noted, but there is no work injury of January 5, 2012 identified even though the record states he was terminated on this date. (Id.).

On June 21, 2012, Petitioner returned to Dr. Panchal complaining of neck pain radiating down the right arm. Two weeks of therapy had not made any difference. His right hand grip was weak. An EMG and therapy were recommended. (Id.).

On July 20, 2012, Petitioner presented to Dr. Babak Lami for an IME at Respondent's request. Dr. Lami notes an alleged January 2012 incident when lifting a 100 pound fuel tank with increased neck and arm pain. The doctor noted no symptoms consistent with right arm radiculopathy. Dr. Lami noted no mention of a new injury in Dr. Panchal's records following the alleged January 5, 2012 date of loss. (RX #11, Deposition Exhibit #4).

Dr. Lami reviewed the January 9, 2012 cervical MRI films, indicating they fail to show any neurocompressive pathology, degenerative changes, and evidence of previous surgery with resection of the disk herniation were noted. Dr. Lami noted the loss of reflexes documented by Dr. Panchal is from the previous disc herniation. The recent EMG failed to show any new findings. Based on his finding of no objective new findings to support Petitioner's complaints, he could not support any further treatment. He did note lateral epicondylitis, which was not related to either alleged work incident. Petitioner had achieved MMI and he could return to full duty work. Dr. Lami does note regarding the alleged January 2012 injury a neck sprain may have occurred. (Id.).

On July 30, 2012, Petitioner returned to Dr. Panchal complaining of neck pain, right shoulder pain, and some pain going down the right arm. An EMG and therapy were again recommended. (PX #5).

On August 30, 2012, Petitioner followed up with Dr. Panchal complaining of neck pain radiating down the right arm. The impression was cervical radiculopathy on the right side. An EMG was recommended and Petitioner was to be off work for a month. (Id.).

On September 24, 2012, an Application for Adjustment of Claim with case number 12 WC 33153 was filed alleging a date of accident "on or about" January 5, 2012. RX #2. Petitioner did not know why there was a seven month gap in the filing of his two Applications for Adjustment of claim even though the Application for the 2010 claim was filed in February 2012, which was after the alleged January 2012 claim. (Tr. at 66-67).

On September 28, 2012, Petitioner returned to Dr. Panchal with the same complaints reported on August 30, 2012. A cervical MRI was recommended. He was to remain off of work. (PX #5).

Petitioner was evaluated by Dr. Michael Treister, an orthopaedic surgeon, at the request of his attorney on November 23, 2012. After reviewing the history and medical records and performed an orthopedic examination, Dr. Treister concluded that at the moment of and immediately following the September 4, 2010, accident, Petitioner had neck and upper right extremity pain and numbness consistent with an injury to the C8 nerve root which exits the spine at the C7-T1 disc space. The MRI performed four days after the accident showed a large postereo-lateral disc herniation on the right side of C7-T1, which is where the right C8 nerve root lies. Despite an initial reduction in radicular pain, evidence of C8 nerve root damage persisted after the surgery. Petitioner's complaints and physical findings after the January 5, 2012, accident were most consistent with re-injury and/or additional injury at the C7-T1 level with further irritation and/or damage to the C8 nerve root. Some findings, said Dr. Treister, pointed toward C7 nerve root irritation. According to Dr. Treister, C7-T1 disc pathology is particularly vulnerable to complications from treatment and time passage. He explained that the level is difficult to reach, and that a posterior approach introduces an element of instability by virtue of the laminectomy, itself, as well as the foraminotomy, and that a posterior fusion is usually not done in conjunction with a posterior disc removal, thus leaving the C7-T1 disc open to the development of instability associated with progressive degenerative

changes in the disc. At the time of his examination Dr. Treister found profound C8 sensory deficit, focal anterior tenderness of the disc suggesting additional deterioration, absent triceps reflex, motor weakness, muscle atrophy and ongoing subjective complaints, nearly all of which were consistent with active, ongoing pathology at C7-T1. Dr. Treister found the most recently performed MRI study performed on Petitioner to be insufficient, as it did not precisely visualize the C7-T1 level. He recommended a high quality, state-of- the- art MRI of the cervical spine, including multiple views of C7-T1, to be followed by evaluation by a university-affiliated neurosurgeon who had not been part of the patient's treatment. He opined that at no time had Petitioner reached maximum medical improvement, as from the time of the surgery until the time of his examination Petitioner had ongoing pathology and advancing segmental instability of the C7-T1 disc space. He further opined that Petitioner was incapable of gainful employment because of pain, weakness and numbness in his dominant upper right extremity, neck and right shoulder (PX9).

Surveillance video was submitted and viewed of Petitioner from November 5, 2012. (Tr. at 71-73, RX #13). Petitioner can be observed cleaning the windshield of a large sport utility vehicle, which he testified was his and was the vehicle his wife drove to court on the date of trial. (Id.). The video shows Petitioner driving the vehicle to the appointment with Dr. Panchal on this date. (Id.) He was observed walking as well. (Id.). Petitioner testified he still drives. (Tr. at 73).

On December 13, 2012, Dr. Panchal indicated he did not recommend surgical treatment. (PX #6).

On February 6, 2013, Dr. Lami drafted a record review report. Dr. Lami indicated in his report Dr. Treister is not a spinal surgeon and questioned why Dr. Treister was opining regarding Petitioner's spine. He noted the thoracic MRI from Centegra was not only adequate, but one of the best quality MRIs, and noted Dr. Treister had no basis upon which to opine Petitioner's condition would deteriorate without surgery. Dr. Lami also included the article cited by Dr. Treister and indicated there is nothing in the article which supports Dr. Treister's conclusions. (RX #11 at 38-41, Deposition Exhibit #5).

On April 24, 2013, Petitioner presented for a cervical MRI. The impression revealed degenerative changes in the cervical spine resulting in mild central canal stenosis with mild/moderate bilateral foraminal stenosis at C4-5, mild central canal stenosis with mild bilateral foraminal stenosis at C5-6, mild central canal stenosis and mild left foraminal narrowing at C3-4, and mild right foraminal stenosis at C7-T1. (PX #6).

On May 13, 2013, when he saw the Petitioner, Dr. Panchal indicated that the MRI showed post-operative changes at C7-T1, narrowing of the neuroforamina at C7-T1 with uncovertebral hypertrophy, mild bulging at C6-C7 with a small right paracentral disc disorder and mild central spinal stenosis at C4-C5. He discussed possible treatment options with Petitioner including undergoing an anterior surgical approach at the level of C7-T1 and C6-C7 or a posterior cervical decompression with a fusion, or having ongoing conservative treatment and living with his pain. Petitioner was given the name

of Dr. Richard Broderick at Northwest Community Hospital for another opinion, and Dr. Panchal stated that he remained incapable of returning to work (T.38-39, PX5, 6). Petitioner tried to see Dr. Broderick but was unable to do so without approval from Respondent. On January 13, 2014, Dr. Panchal referred him to Dr. George Cybulski, a neurosurgeon at Northwestern Memorial Hospital.
Petitioner was examined on February 14, 2014, by Dr. Cybulski, who also reviewed his MRI, confirmed the diagnosis of C8 radiculopathy on the right and recommended that he undergo a C7-T1 anterior cervical discectomy and fusion for his work-related injury (p.40-41, PX6, 7).

On September 14, 2014, Petitioner complained to Dr. Panchal of ongoing pain and weakness, deterioration in his quality of life and inability to function effectively in his day-to-day activities. Dr. Panchal expressed concern that because the symptoms had persisted for such a long time they might not resolve even after successful surgery. He recommended that Petitioner live with his deficiencies and imitations. Petitioner has not seen Dr. Panchal again (p. 41, PX6).

Petitioner, who in the past did not want another surgery, has changed his mind and now wants to proceed with the proposed surgery (p.41).

At hearing, Petitioner testified that he has difficulty sleeping at night due to pain. When he wakes up in the morning, it is hard for him to stretch out without cramping up. In the shower, if he tries to use both hands to wash his hair, it feels as though his incision is separating. If he bends over to tie his shoes, his arm feels as though it is on fire. He tries to keep busy during the day with small tasks such as mowing the lawn, but he cannot mow uphill without severe pain in his neck, which gives him a bad headache. He lacks enough strength to open jars. He has experienced seven episodes over a period of six months when he suddenly experiences pain so severe in his neck that he loses all power over everything and is dropped to his knees (T.42-43).

Petitioner testified that he has tried working in two positions since being terminated by Respondent. Each position lasted for only one day. He was hired to drive a cargo van, and by the time he had driven from Des Plaines to Louisville, Kentucky, he was in such severe pain that, he could not go on. He had to call the owner to come get him. He secured another position doing cleaning in a market, but he did not have enough strength to take apart a meat cutter he had been told to clean, and he had to take breaks during the day due to the cramping he was experiencing. At the end of the day, he was told by his boss that the job was not for him (Tr. at 44).

In response to questioning by Respondent's counsel Petitioner testified that he received unemployment compensation benefits from January 22, 2012, through June 16, 2012 (Tr. at 62-63), and that in February 2015, he was awarded Social Security disability benefits which were retroactive, as best he recalled, to a date in 2012 (Tr.at 69-70). Petitioner further acknowledged that he owned and used his own tools while he was employed by Respondent, that he kept them in a tool box which was about three feet by two feet by two feet, that everyone else had a Snap-On box, whereas his came from Menards, and that, in his estimation, the box weighed about 500 pounds (Tr. at.47-49).

Conclusions of Law

F. Is Petitioner's current condition of ill-being causally related to Petitioner's September 10, 2010 work accident? and (K) Is Petitioner entitled to prospective medical treatment?

It is undisputed that as a result of Petitioner's September 4, 2010, accident, Petitioner sustained a large disc herniation at C7-T1 for which he underwent surgery in November 2010. He initially reported that the radiating pain in his right arm was gone but that he still had pain in his neck. Gradually, he reported the return of occasional pain down his right arm, as well as weakness in the upper extremity. In April 2011, five months after his surgery, Dr. Panchal noted restricted and painful neck movement, weakness of right hand grip, weakness in the right triceps and a hypoactive, almost absent, right triceps reflex (PX2).

Based upon a Section 12 examination by Dr. Lami on April 1, 2011, Petitioner was returned to full duty work on June 3, even though Dr. Panchal had prescribed additional work hardening and had not yet released Petitioner to work of any kind (Tr.at 23-24. PX2).

When Petitioner returned to work he noted significant weakness and increased pain. By the fall of 2011, his symptoms were increasing and he was having trouble keeping up at work. Simple tasks took him much longer to complete. He testified as to some of the specific difficulties he encountered, including trouble squeezing the trigger on a grease gun, swinging a hammer/mallet and unhooking an air hose (Tr. at 24-26, 78-79). Respondent's disciplinary reports actually corroborate those difficulties (RX5).

On December 12, 2011, Dr. Panchal again noted weakness of Petitioner's right hand grip, as well as significant atrophy of the first interosseous muscle on the right and almost absent right triceps reflexes. The doctor diagnosed right cervical radiculopathy and ordered a cervical MRI and EMG/nerve conduction study of the right upper extremity (PX2).

Beginning on February 27, 2012, and continuing thereafter, Dr. Panchal ordered a new MRI of the cervical spine, but it was not approved and therefore not performed until April 24, 2013. After reviewing the new MRI, Dr. Panchal discussed treatment options, including another surgery using an anterior approach. (PX2,5).

On January 13, 2014, Petitioner saw Dr. Cybulski, upon referral of Dr. Panchal. Dr. Cybulski also reviewed the MRI, confirmed the diagnosis of C8 radiculopathy on the right and recommended a C7-T1 anterior cervical discectomy and fusion. (PX7).

At hearing, Petitioner testified that he is tired all the time because he has difficulty sleeping due to pain. Activities of daily living such as washing his hair, tying his shoes, or even stretching upon arising, are difficult because of pain and cramping. He has experienced episodes of such severe neck pain that it drops him to his knees (Tr. p.42-43). The Arbitrator notes that he called Dr. Panchal's office to report at least one such

episode (PX6). Petitioner has determined that he now wishes to proceed with the recommended surgery (Tr. p.41).

Nothing in the surveillance report or disc introduced into evidence by Respondent (RX 12 and 13) which shows him using a squeegee to clean the windshield of his Ford Excursion, contradicts or calls into question Petitioner's testimony regarding his current condition of ill-being.

Dr. Treister, a Board certified orthopaedic surgeon, testified that he performed approximately a thousand cervical spine surgeries over the course of his practice. According to his testimony, Petitioner's condition of ill-being was caused in whole or in part by his accidents in September 2010, and January 2015. He based his opinion upon the onset of symptoms at the C7-T1 level with right-sided C8 radiculopathy, which Petitioner had not had previously, with essentially no change in those symptoms (PX8-p. 5, 55-56, 31) He explained that when a disc herniation occurs in the cervical spine, simply removing the removing the disc will relieve the symptoms in the short term. As soon as any collapse occurs, however, there will be little space where the nerve roots exit the cervical spine. As a result, there will be secondary pressure on the nerve root, and the radiculopathy will recur. He stated that was especially true at the C7-T1 level. At most other cervical levels surgeons routinely use an anterior approach and do a fusion, which prevents the problem by pushing the vertebrae apart from one another, opening the neural foramen and taking the pressure off the nerve. The issue with the C7-T1 level is the difficulty in accessing it. When a posterior approach fails, an anterior approach becomes necessary (PX8-p.29-30).

In Dr. Treister's opinion, Petitioner has a very florid, active C8 radiculopathy on the right which needs to be addressed. Surgery could provide some motor recovery, some sensory recovery and pain relief, with pain relief being the most likely. Nerve recovery is more uncertain and takes a long time. He testified that there is no chance of improvement without the surgery. Once there has been a disc herniation in the cervical spine, he testified, the natural progression is for the disc space to narrow. As the disc space narrows, the space where the nerves exit is automatically narrowed, because the top or roof of the space is from the vertebra above, and the floor is from the vertebra below. If the disc space narrows, the neural foramen narrows, and the nerve root is entrapped. In addition, a collapse of disc space causes the periphery around the spinal canal to become smaller, resulting in spinal stenosis. For now Petitioner does not have much spinal stenosis at the C7-T1 level; it's just a question of the nerve root being trapped in the foramen, as was demonstrated on the most recent MRI. Eventually, however, he will have a combination of crushing of the nerve root in the foramen and spinal stenosis, because it is a progressive phenomenon (PX8-p.33, 56-59, 32).

Respondent's examining orthopaedic surgeon, Dr. Lami, disagreed with Dr. Treister. He opined that Petitioner had reached maximum medical improvement for his September 2010, injury; that his alleged January 2012, injury had probably been a sprain; that no further treatment was needed for either injury; and that Petitioner was capable of resuming full duty work. He diagnosed Petitioner as having lateral epicondylitis, also known as tennis elbow, unrelated to any work injury (RX11-p.25, 27, 28).

The chronology of events in this case supports the conclusion that, notwithstanding the surgery performed at the C7-T1 level for Petitioner's September 4, 2010, injury which provided some temporary relief, nerve damage persisted, causing ongoing symptoms, impairment and disability for Petitioner. The Arbitrator finds Dr. Lami's opinions less persuasive as they are contradicted by Dr. Panchal, Dr. Cybulski, and Dr. Treister. The Arbitrator was persuaded by Dr. Treister's opinions which were thorough and well-reasoned.

Based upon the evidence contained in the record, the Arbitrator concludes that Petitioner's condition of ill-being is causally related to his injuries and that he is entitled to prospective medical care, namely a C7-T1 anterior cervical discectomy and fusion.

G. What were Petitioner's earnings?

On direct examination Petitioner testified he had to work until the job was complete and that overtime was mandatory. (Tr. at 8). On cross examination Petitioner was questioned regarding an October 14, 2011 disciplinary report where he was written up for failure to follow instructions and substandard work. (Tr. at 54 and RX #5 at 11). The report indicates Petitioner was assigned a job, which should not have taken more than two hours, and after three and a half hours he still did not complete it. At the end of the day the job was still not finished and had to be assigned to someone else. (RX #5 at 11). Petitioner admitted this report is in conflict with his testimony that he had to work until jobs were complete. (Tr. at 54).

Respondent witness Joe Goodman testified there is no mandatory overtime at Respondent and no policy requiring overtime. (Tr. at 89-90). The Arbitrator finds no indication that overtime was mandatory in Respondent's General Work Guidelines. (RX #5 at 4-8).

Based on the foregoing discussion the Arbitrator finds overtime was not mandatory. Respondent Exhibit #3 was submitted into evidence without objection. It indicates Petitioner earned $16,047.00 in the 23 week period prior to the September 4, 2010 injury. The Arbitrator finds Petitioner's average weekly wage of **$697.70.**

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?

According to Petitioner's exhibits 4, 7 and 11 and Petitioner's testimony, the Arbitrator finds that Petitioner incurred the following bills for medical treatment necessary to cure or relieve him of the effects of his accidental injuries:

Dr. Kanu Panchal	$900.00
Dr. N.V.R Raju/Regional Cardiology Consultants	$547.44
Dr. George Cybulski/Northwestern Medical Group	$460.00

In view of the Arbitrator's conclusions regarding accident and causal connection, the Arbitrator concludes that Petitioner is entitled to receive payment from Respondent for the above Bills, subject to the fee schedule of Section 8.2.

L. What temporary benefits are in dispute?

Following his undisputed September 4, 2010, accident, Petitioner was off work from September 5, 2010, through June 2, 2011, a period of 38 and 5/7 weeks, per the directions of the Advocate Good Shepherd Hospital emergency room and Dr. Panchal. On May 21, 2012, Dr. Panchal took him off work again and has kept him off work through the date of hearing, a period of 164-1/7 weeks. At the time Dr. Treister examined Petitioner on November 1, 2012, he opined that because of pain, weakness and numbness in his dominant right upper extremity, shoulder and neck, it was unlikely he could be gainfully employed (PX9).

The Arbitrator concludes that Petitioner is entitled to compensation for **202-6/7 weeks** of temporary total disability, subject to credit for payments made.

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 UP	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

LINDA V. BARTOLOMEO
Petitioner,

17IWCC0024

vs.

NO: 07 WC 54543

COOK COUNTY SHERIFF'S DEPARTMENT,

Respondent.

DECISION AND ORDER ON REMAND FROM THE CIRCUIT COURT

This cause comes before the Commission pursuant to the Order of the Circuit Court, entered April 27, 2015.

On October 15, 2008 a 19(b) hearing was held before Arbitrator Galicia. Petitioner, a deputy sheriff, testified that on October 11, 2007, while descending stairs to go to a restroom one floor down, she fell on the stairs, and that her foot became stuck right before the yellow non-skid strip on the stair. She speculated that her right foot must have got stuck in gum or candy, that she often observed trash on the stairs in the past from children visiting the Women Crisis Center on the lower level, or from the cafeteria or the medical department.

On October 31, 2008 Arbitrator Galicia issued a 19(b) Decision finding that Petitioner sustained accidental injuries arising out of and in the course of her employment on October 11, 2007, Petitioner's current condition of ill-being is causally connected to the accident, Petitioner was temporarily totally disabled for a period of 31-4/7 weeks, from 10/11/07, through 5/18/08, at the rate of $677.96 per week, and that Respondent shall pay $33,415.39 for medical services, as provided in Section 8(a) of the Act. The Arbitrator found Petitioner was injured on a stairway used by the general public, but she was exposed to greater risk than the general public because she was to use the flight of stairs on a continual basis to seek personal comfort during her workday to use the restroom. The Arbitrator found that Petitioner's foot became stuck either by

the non-stick tape or by the gum/candy on the stairs. The Arbitrator found accident arising out of and in course of employment based upon finding that Petitioner was carrying and listening to her radio in her left hand while descending the stairs, which contributed to her fall and injures, as her left hand was one closest to railing and her left hand was needed to grab railing to prevent fall. The Arbitrator relied upon Nabisco Brands v. IC, 266 Ill.App.3d 1103(1994) and reasoned Petitioner's carrying of the radio greatly increased the dangerous effects of the fall, and contributed to the fall and her injuries.

On November 12, 2008, Respondent filed a Petition for Review, raising issues of accident, arising out of and in course of employment, medical expenses, and TTD.

This matter was heard on September 9, 2009 by a panel of Commissioners comprised of Lamborn, Sherman, and Rink. On February 11, 2010, the Commission, under 10 IWCC 150, reversed the Arbitrator's decision and found Petitioner failed to prove she sustained accidental injuries arising out of and in the course of her employment with Respondent, that Petitioner's fall on the stairs was as result of a neutral risk to which the general public was equally exposed and denied Petitioner's claim for compensation. The Commission, relying on First Cash Financial Services v. Industrial Commission, 367 Ill.App.3d 102, 853 N.E. 2d 799, 304 Ill.Dec. 722 (2006), found no reasonable certainty that Petitioner's injuries stemmed from a risk associated with her employment. Although Petitioner speculated that she slipped on gum, candy, or debris, the Commission found that it is equally possible to infer that the stairs were free of any debris and that there was no other evidence in the record to support Petitioner's speculation as to the cause of her fall. Petitioner fell while using stairs used by the general public. Petitioner was not providing building surveillance, requiring her to go up and down stairs all day, but instead traveling down to the lower level as the bathroom on the floor she was working on was being serviced at that particular time of the day. The Commission also found Petitioner's testimony as to the cause of her fall – possible candy or gum on the stair right before the yellow non-stick strip tape- was inconsistent with the ambulance report, Petitioner's written statement on the date of accident, the supervisor's investigation report, the witness statement, and the initial treating records. The witness statement, witness memo and the supervisor's report make no mention of Petitioner carrying a radio, slipping on gum or candy or debris.

Petitioner appealed the Commission's Decision and Opinion on Review. In a December 31, 2010 Order, the Circuit Court of Cook County confirmed the Decision of the Commission. Petitioner appealed the Circuit Court's Decision.

On December 27, 2011, the Appellate Court issued a Rule 23 Order finding the Commission's decision was lacking in findings which made a meaningful judicial review possible, vacating the judgment of the Circuit Court which confirmed the Commission Decision, vacating the Commission's Decision which found that the claimant's "fall on the stairs was a result of a neutral risk to which the general public was equally exposed," and remanding the matter back to the Commission with directions "to issue an amended decision containing specific findings as to the risk to which the claimant was exposed that caused her to fall." On November

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20, 2012, Judge Margaret Ann Brennan issued an order ordering the Clerk of the Circuit Court of Cook County to transfer the record of the proceedings in this matter back to the Commission.

On March 22, 2013 and July 22, 2014 Petitioner's attorney made written requests for Oral Argument because two of the Commissioners on the panel who previously heard this matter were no longer sitting. Petitioner argued that because two (2) of the present panel members assigned to this matter were not present for the September 9, 2009 Oral Argument, the present panel may not make substantive decisions that go beyond mere ministerial acts. Petitioner's attorney argued that the failure to allow Oral Arguments would deprive Respondent due process and create more issues on appeal.

On December 12, 2014, the Commission issued decision 14 IWCC 1076 signed by Commissioners Lamborn, Tyrell and Brennan. On March 6, 2015, the Commission recalled 14 IWCC 1076 and issued Corrected Decision 14 IWCC 1076. The Commission Decision acknowledged that following the Commission's February 11, 2010 Decision, the Panels of the Commission were reconfigured. The Decision in 14 IWCC 1076 also acknowledged that on March 22, 2013, following the Appellate Court Remand Order, Petitioner's attorney filed a Petition for Oral Arguments under Section 19(e) requesting oral arguments on Remand and so a decision could be rendered by a majority of Commissioners who were present at said argument. The Commission noted Petitioner cited no case law in support of the argument for additional oral arguments. The Commission noted that the Appellate Court instructed "the Commission to issue an amended decision containing specific findings as to the risk to which the Claimant was exposed that caused her to fall." Accordingly, the Commission denied Petitioner's Petition for additional Oral Arguments.

On April 27, 2015, Judge James M. McGing of the Circuit Court of Cook County issued an Order setting aside the Commission's Decision in 14 IWCC 1076 finding that the Commission did not comply with requirements of 820 ILCS 305/19(e) because the Commission's decision assigned case number 14 IWCC 1076 was not decided by a majority of Commissioners present at the September 9, 2009 oral argument. The Commission was ordered to "hear oral arguments by the parties and render a decision by the majority of the Commissioners present for said oral argument."

820 ILCS 305/19(e) of the Statute provides in relevant part:

> In the event that either party requests oral argument, such argument shall be had before a panel of 3 members of the Commission....which shall be comprised of not more than one representative citizen of the employing class and not more than one representative citizen of the employee class....A decision of the Commission shall be approved by a majority of Commissioners present as such hearing if any; provided, if no such hearing is held, a decision of the Commission shall be

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approved by a majority of a panel of 3 members of the Commission as described in this Section. 820 ILCS 305/19(e)

The Clerk of the Circuit Court transmitted the record from the Circuit Court of Cook County to the Illinois Workers' Compensation Commission on August 13, 2015. The Commission conducted an Oral argument on July 26, 2016.

The Commission, based upon the April 27, 2015 Circuit Court Remand Order and after reviewing the entire record, reverses itself on the issue of accident for the reasons stated below, modifies the Arbitrator's decision regarding accident, and otherwise affirms and adopts the October 31, 2008 Decision of Arbitrator Galicia finding that Petitioner sustained her burden of proving that she sustained accidental injuries arising out of and in the course of her employment on October 11, 2007, that a causal relationship exists between those injuries and her current condition of ill-being for her left ankle, neck, right shoulder and lower back, and that Petitioner was temporarily totally disabled from October 11, 2007 through May 18, 2008, a period of 31-4/7 weeks.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

In the course of her employment on October 11, 2007 Petitioner, a deputy sheriff for 17 years for the County, fell at approximately 9:15 a.m. when she left her post in the Rolling Meadows Municipal District Courthouse to use the restroom. Petitioner's job function on that day was front door security and to screen people when they came into the courthouse. Petitioner was wearing her uniform, a gun belt which weighs 11 pounds that has handcuffs, four keepers and usually "we keep our radio in the back," but Petitioner did not keep her radio in the back, she would keep her radio on top of the machine. (T, 11-12) The County allows its deputies to leave their post to use the restroom so long as the deputy notifies his or her partner prior to leaving. (T, 38-39) Petitioner took her radio with her to monitor the front door where her partners were working that morning. Her usual partner was off sick and the substituting female partner was not familiar with the front door security so she was listening to the radio. If she was needed, she would have received a call on her radio and returned to her post. (T, 15) If she had to respond to an emergency, and she was in the bathroom, she has to hurry up, put on her gun belt and go back to the front door. (T, 39, 43)

Petitioner worked on the first level and attempted to use the restroom located on the same first level, however, the custodian was cleaning that restroom so she proceeded to the women's restroom on the lower basement level. (T, 12) To get to the lower level, Petitioner had to descend a public staircase consisting of two sets of stairs with a landing in the middle and that had a railing on each side. The stairs were made of marble looking material and had yellow non-skid strips affixed to the front of each stair. (T,13) Petitioner testified that while carrying her radio in her left hand, Petitioner descended the first flight of stairs to the landing on the left side. She began descending down the second set of stairs next to the left railing. She "got tied up going down the stairs" and the first reaction that she had was to protect her face, so she threw the radio

on the ground to grab the railing and she twisted her body to grab the railing. As she grabbed the railing, she twisted her whole body and she just fell and "ended up on her butt on the last step." (T, 14-16) As she was descending the stairs, she "got stuck on her right foot" and went face forward; as she went forward she had to grab something; that was when she threw the radio and went forward to grab the rail. Her right foot got stuck right before that yellow tape. (T, 16) She thought it had to have been candy or gum because she had always observed trash or debris on the stairs in the past. (T, 17)

Petitioner was taken by ambulance to Northwest Community Hospital. The ambulance report documents a history of "twisting her ankle while walking down the stairs; she was falling down the stairs and caught herself on the rail. She did not strike her head and her only complaint was the pain to the left ankle." (Px2) The hospital's emergency room records history reflects that she "slipped on stairs" and twisted her ankle. Neither record corroborates that Petitioner had her radio in her hand. The Petitioner was diagnosed with a left distal fibular fracture, her injury was casted and she was authorized off work. (Px3)

On cross-examination the Petitioner testified that she fell on either candy or gum, "something sticky on that landing—off that landing." Upon return to the courthouse she filled out an accident report. (T, 45) She was on drugs including an old prescription of Norco that she had for pain and nerve damage from a brain tumor and brain surgery that she had in 2001.(T, 71) Petitioner also has neuropathy which was diagnosed in 2002 and when she filled out the accident report she wrote what she was told to write by Pete Kennedy, her union steward who was there to protect her interests. (T, 51-53, 58-59) The report asked for a complete description of how the accident occurred. She wrote: "Going down the staircase to the basement, foot got stuck on non-slip tape. R/O fell forward onto rail and twisted (L) ankle. R/O found out later ankle was broke."(T, 50, 51, Rx1) Petitioner was "wasted" and just wrote anything just to go back home and she would not have written and misspelled words if she was normal and in her right mind, however, all the other information on the incident report was correct. (T, 55) She testified she fell on something sticky and went flying down the stairs. (T, 55)

Her supervisor, Lieutenant Thomas Collins also completed an incident report on the day of the occurrence. Petitioner did not talk to Lieutenant Thomas Collins. She had nothing to do with filling out the report particularly no conversations with Lt. Collins regarding the manner in which she fell. (T, 68)

Under, "(i)n Employee's own words, how did the accident happen? Please describe in detail:" Lt. Collins wrote "D/S Bartolomeo stated that she tripped on a loose piece of tape." The form asked "did you examine the accident area," he then wrote "No loose tape was found at the site - stairs were examined and found to have no deficiencies or flaws." Lt. Collins noted that a witness named Marc Kaplan witnessed the accident. (Rx2) Petitioner did not know Marc Kaplan personally or have anything to do with the content of his report. (T, 70)

Marc Kaplan signed a memorandum that stated that "on 11 Oct 07 at approximately 0920 hours R/O was about to go up staircase when D/S stumbled, lost her balance and twisted (her) ankle." (Rx3) An unsigned, transcribed witness statement from Deputy Sheriff Marc Kaplan described his proximity to Petitioner and that he was "approaching the staircase from below on lower level." He observed D/S Bartolomeo catch the sole of her shoe on nonskid strip on the 4th or 5th step from the bottom and then lost footing and fell." (Rx4) Neither Lt. Collins' nor Deputy Sheriff Kaplan's reports reflect that Petitioner had a radio in her hand at the time of her fall.

An employee's injury is compensable under the Act only if it arises out of and in the course of employment. 820 ILCS 305/2 (West 1998). Both elements must be present at the time of the claimant's injury in order to justify compensation. *Illinois Bell Telephone Co. v. Industrial Comm'n*, 131 Ill.2d 478, 483, 546 N.E.2d 603 (1989). It is undisputed that the Petitioner sustained her injuries "in the course of" her employment. Petitioner was going to the restroom when the fall occurred, similar to the claimant in *Illinois Consolidated Telephone Co. v. Industrial Comm'n.* In that case, Justice Rakowski wrote a concurring opinion, "Thus, it is overwhelmingly clear that our only focus should be on whether claimant's injury arose out of employment, specifically, whether the claimant's act of traversing stairs exposed her to a risk of injury greater than that to which the general public is exposed. Because the personal comfort doctrine is an "in the course of" concept and the sole issue in this case is whether claimant's injury arose out of her employment, the (personal comfort) doctrine has no application." *Illinois Consolidated Telephone Co. v. Industrial Comm'n,* 314 Ill.App.3d 347, 352-53 (2000) (Rakowski, J., concurring).

Arising out of the employment refers to the origin or cause of the claimant's injury. As the Supreme Court held in *Caterpillar Tractor Co. Industrial Comm'n*, 129 Ill.2d 52, 58 (1989):

> For an injury to "arise out of" the employment its origin must be in some risk connected with, or incidental to, the employment so as to create a causal connection between the employment and the accidental injury. (*Jewel Cos. v. Industrial Comm'n* (1974), 57 Ill.2d 38, 40; *Chmelik v. Vana* (1964), 31 Ill.2d 272, 277.) Typically, an injury arises out of one's employment if, at the time of the occurrence, the employee was performing acts he was instructed to perform by his employer, acts which he had a common law or statutory duty to perform, or acts which the employee might reasonably be expected to perform incident to his assigned duties. (*Howell Tractor & Equipment Co. v. Industrial Comm'n* (1980), 78 Ill.2d 567, 573.) A risk is incidental to the employment where it belongs to or is connected with what an employee has to do in fulfilling his duties. *Orsini v. Industrial Comm'n* (1987), 117 Ill.2d 38, 45; *Fisher Body Division, General Motors Corp. v. Industrial Comm'n* (1968), 40 Ill.2d 514, 516; see, *e.g., Peel v. Industrial Comm'n* (1977), 66 Ill.2d 257 (claimant injured while pushing vehicle which was blocking entrance to parking lot); *Union Starch, Division of Miles Laboratories, Inc. v. Industrial Comm'n* (1974), 56 Ill.2d 272 (claimant injured during break on employer's roof).

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> If an employee is exposed to a risk common to the general public to a greater degree than other persons, the accidental injury is also said to arise out of his employment. (*Orsini v. Industrial Comm'n* (1987), 117 Ill.2d 38, 45; see, *e.g., Chmelik v. Vana* (1964), 31 Ill.2d 272, 278....However, if the injury results from a hazard to which the employee would have been equally exposed apart from the employment, or a risk personal to the employee, it is not compensable. *Material Services Corp. v. Industrial Comm'n* (1973), 53 Ill.2d 429, 433

Risks are thus categorized into three groups: 1) risks distinctly associated with the employment, such as the risk of tripping on a defect at the employer's premises; 2) risk personal to the employee, such as idiopathic falls; and 3) neutral risks that have no particular employment or personal characteristics and to which the general public is equally exposed. First Cash Financial Services v. Industrial Comm'n, 367 Ill.App.3d 102, 105-106, 853 N.E.2d 799 (2006); *Illinois Consolidated Telephone Co. v. Industrial Comm'n,* 314 Ill.App.3d 347, 352-53 (2000) (Rakowski, J., concurring).

Descending the public staircase stairs was not an act incidental to Petitioner's employment. Petitioner's job duties did not require that she go to the lower level of her building and she went to use the lower level restroom because the custodian was in the first floor bathroom, thus there is no indication that she traversed those stairs on more than one occasion the date she fell, or any day.

There is medical evidence to suggest that Petitioner could have had an idiopathic fall, however, no testimony or medical opinions offered in this regard. The Petitioner was diagnosed with probable endolymphatic hydrops in 2008, after having an abnormal ECOG bilaterally and complaints of right high-frequency sensorineural hearing loss. Dr. Maciorowski's December 17, 2007 office note shows that the Petitioner's current medications included Zonisamide, 4 tablets daily, and Lyrica that were prescribed by Dr. Mikesell for seizure and neuropathy. The Spine Center's January 15, 2008 office note confirms her brain surgery left her with some visual problems. Even if Petitioner's medical condition contributed to her fall, the analysis must go further to examine whether any other condition of employment contributed to her fall.

Therefore, the subject incident, descending a public staircase, falls under the line of cases where injuries result from a neutral risk. As a general rule, neutral risks generally do not arise out of the employment and are compensable under the Act only where the employee was exposed to the risk to a greater degree than the general public. Illinois Institute of Technology Research Institute, 314 Ill. App. 3d at 163.

As a matter of law, just walking on stairs does not establish an increased risk caused by the employment. *Oldham v. Industrial Commission Id.* There needs to be at least an inference in the record that the injury could have been due to a risk peculiar to the employment. *Ceas v. Industrial Commission,* 261 Ill.App.3d 630, 199 Ill.Dec. 198, 633 N.E.2d 994 (1st Dist. 1994). The Illinois Courts have noted that the mere fact that a claimant fell on a stairway is insufficient

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to prove increased risk, however, an increased risk can arise if the stairs are defective. *Illinois Consolidated Telephone v. Industrial Commission*, 732 N.E.2d 49 (2000), 314 Ill.App.3d 347, 247 Ill.Dec. 333, 732 N.E.2d 49 (5th Dist. 2000).

In *Illinois Consolidated Telephone*, the Court found that a Commission decision finding that the claimant sustained injury which arose out of her employment while descending stairs, was not against the manifest weight of the evidence.

Justice Rakowski specially concurring wrote that "Because claimant was wearing high heels, some of the stair treads were worn, hand rails were not provided where claimant fell, and the stairs were slippery, the Commission could properly conclude that claimant was exposed to a risk of injury greater than that to which the general public is exposed." *Id* at 52.

... because unexplained falls result from a neutral risk, resultant injuries arise out of employment only where claimant can show that he or she is exposed to a risk greater than that to which the general public is exposed. If claimant cannot make such a showing, the injury does not arise out of employment. The increased risk may be qualitative, such as the dangerous nature of the stairs in the instant (*Illinois Consolidated Telephone*) case, or quantitative, such as where the employee is exposed to a common risk more frequently than the general public. *Id* at 56.

In the subject case, there is no evidence that the Petitioner needed to traverse the stairs multiple times in one day. Therefore, under a neutral risk quantitative analysis, the Petitioner was not exposed to a common risk more frequently than the general public. However, under a neutral risk qualitative analysis, the dangerous nature of the stairs was raised. There was, in fact, corroboration that her foot "got stuck" on something on the stair.

The Commission has considered the testimony of the Petitioner and the report of Deputy Sheriff Kaplan. Though the chronical of events that they related appears divergent, they share a common thread. That is: The Petitioner's foot became stuck or caught on something, which in turn caused Petitioner to fall.

The Commission could have determined that the testimony of the Petitioner was unreliable and denied the claim based upon differences in her testimony and the report of Deputy Sheriff Kaplan. But, to do so would be to ignore the common thread that permeates both accounts of the accident. It is for this reason that the Commission has deemed the first person account of Deputy Sheriff as the more correct of the two and determined that the non-skid tape caused the Petitioner to fall.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Commission's prior decision on Review, 14 IWCC 1076, is vacated and that the October 31, 2008 Decision of Arbitrator Galicia, as modified herein, is affirmed and adopted.

17IWCC0024

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $677.96 per week for a period of 31 4/7 weeks, from October 11, 2007 through May 18, 2008, 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 $33,415.39 for medical services as provided in §8(a) and §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of 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 19 2017
KLW/bsd
O: 7/26/16
42

Kevin W. Lamboth

Thomas J. Tyrrell

Michael J. Brennan

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

Warren Spann,
Petitioner,
vs.

NO: 12 WC 27238

Tri County Coal,
Respondent,

17IWCC0025

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 5, 2015, is hereby affirmed and adopted.

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

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

The party commencing 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 2017
o010517
DLG/mw
049

David L. Gore

Mario Basurto

Stephen J. Mathis

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SPANN, WARREN
Employee/Petitioner

Case# **12WC027238**

TRI COUNTY COAL
Employer/Respondent

17IWCC0025

On 10/5/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.10% 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:

0755 CULLEY & WISSORE
KIRK CAPONI
300 SMALL ST SUITE 3
HARRISBURG, IL 62946

1662 CRAIG & CRAIG LLC
KENNETH F WERTS
PO BOX 1545
MT VERNON, IL 62864

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

Warren Spann
Employee/Petitioner

v.

Tri County Coal
Employer/Respondent

Case # 12 WC 27238

Consolidated cases: n/a

17IWCC0025

An *Application for Adjustment 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 Springfield, on August 28, 2015. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On January 3, 2012, Respondent was operating under and subject to the provisions of the Act.

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

On this date, Petitioner did not sustain an occupational disease 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 alleged occupational disease.

In the year preceding the injury, Petitioner earned $n/a; the average weekly wage was $1,144.67.

On the date of accident, Petitioner was 55 years of age, married with 0 dependent child(ren).

Petitioner has received all reasonable and necessary medical services.

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

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

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

ORDER

Based upon the Arbitrator's Conclusions of Law attached hereto, claim for compensation is denied.

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

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

William R. Gallagher, Arbitrator

September 29, 2015
Date

OCT 5 - 2015

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged he sustained an occupational disease arising out of and in the course of his employment for Respondent. The Application alleged a date of accident (last exposure) of January 3, 2012, and that Petitioner sustained an occupational disease to the "Lungs and/or heart" as a result of "Inhalation of coal mine dust including but not limited to coal dust, rock dust, fumes & vapors for a period in excess of 30 years." (Arbitrator's Exhibit 2). Respondent disputed liability on the basis of no exposure/disease and causal relationship (Arbitrator's Exhibit 1).

At trial, Petitioner testified he was 59 years old and lives in DuQuoin, Illinois. Petitioner graduated from high school and took one welding class at Rend Lake College. Petitioner worked 31 years in coal mining with all of those years being underground. Petitioner testified that in addition to coal dust, he was regularly exposed to and breathed silica dust, roof bolting glue fumes and diesel fumes.

Petitioner last worked a shift in the coal mine on January 3, 2012, at Respondent's Crown III mine. He was 55 years old on that date, and his job classification was repairman. Petitioner testified that he breathed coal dust on that day. Petitioner testified that was his last day of work because his health had been failing for three years prior. He testified he could no longer do his job successfully, and he had sufficient years to retire, so he did. After he retired from coal mining he worked as an over-the-road truck driver for Shawnee Express for 15 months where he earned $400.00 to $500.00 per week. He left that job for health reasons. He testified that his legs would swell because of his diabetes. He testified that he would be short of breath when anking the dollies up and down and lifting trailers up.

Petitioner started working in a coal mine in 1975 for Old Ben as a shuttle car operator. In that job he hauled the coal from the face to the belt tail to dump it. Petitioner worked for Ziegler Coal Company from January to May 1977, as a shooter. Next he went to work for Respondent at Orient No. 6 from 1977 to 1979. His job there was roof bolter. He also ran a continuous miner which is the machine that actually cuts the coal out of the mine. He also worked at Orient No. 4 from 1980 to 1981 as a roof bolter. He testified that in that mine there was a rock top and the rock dust would come down on him when he was drilling. He worked at Orient No. 6 again from 1981 to 1991 running the scoop, hauling roof bolt materials and scooping up coal dust and gob. He then went back to Orient No. 4 again from 1994 to 1996 where he worked as a longwall repairman. Petitioner worked at Crown II mine for Freeman from 1997 to 2007. In that job he repaired all the face equipment, diesel rides, electrical boxes and belt tails. All that work was done on machines in the mine. He had the same exposures as the other miners. He was also exposed to roof bolting glue fumes. Petitioner then worked at Respondent's Crown III mine from March, 2008, until he left the mine. At that mine he worked as an underground repairman on a production unit where there was a lot of dust. He was also exposed to glue and diesel fumes. During times that he was laid off and the mine was closed Petitioner would drive a truck.

Petitioner testified that he first noticed breathing problems at work in 2009. He testified that he would get short of breath, and become exhausted more quickly and have to rest more. He was working as a repairman when he first noticed these problems. He testified that from the time he

first noticed breathing problems until he left the mine, they continued to worsen. He testified that since leaving the mine his problems have gotten worse. Petitioner testified that he could probably walk five minutes on level ground at a normal pace before becoming short of breath. He testified that he could climb 12 to 15 stairs before having to rest. Petitioner was not taking any breathing medications at the time of trial. Petitioner testified that his treating physician was Dr. Christopher Reyes and that he had spoken to him about his breathing problems. He testified that Dr. Reyes was aware of his occupation. He also treated with Dr. Dennis Swenie while he was at the Crown mine. He testified that he talked to Dr. Swenie several times about his breathing. Petitioner testified that he never smoked. In addition to his diabetes for which he takes medication, he has neuropathy and cholesterol problems.

Petitioner testified that about a week after he last worked for Respondent, he signed a resignation with the company. He testified that when he executed that resignation, he severed all rights of recall to the mine. He testified that the following month he applied for Social Security Disability. Petitioner testified that he received a normal retirement pension, not a disability pension from the mine. Petitioner testified that when he applied for Social Security Disability, he was honest in his application for those benefits as to the physical problems that kept him from working. When working for Shawnee Express, Petitioner was delivering tires from Continental Tire in Mt. Vernon to the Yokohama Warehouse in Louisville. Petitioner had a CDL license which was still current as of trial. Petitioner applied for Social Security Disability again after he left Shawnee Express in July or August of 2013. He was denied again.

Petitioner had back surgery in March 1981. He had a severe ruptured disc between L4 and L5 and a bulge between L3 and L4. Petitioner had his right knee operated on in November 1991 and again in 2000. The left knee was operated on in October, 2005, and March, 2006. He has arthritis in his right shoulder. He also suffers from diabetic neuropathy in his legs. Petitioner testified he has sleep apnea, but he does not use a CPAP.

Petitioner testified that for recreation he goes boating on occasion. He does not fish much anymore because he cannot stand up and throw the rod. He lives on the lake and the boat is right there at his house. He testified that he goes camping once or twice a year.

Petitioner testified that if he goes grocery shopping with his wife, he has to sit in the truck or sit down in the store because he cannot make it up and down the aisles. He has to have his yard mowed because of breathing issues. He testified that it has been two years since he has mowed his own yard.

Dr. Glennon Paul is the Director of St. John's Respiratory Therapy and a Clinical Assistant Professor of Medicine at SIU Medical School (Petitioner's Exhibit 1, p. 6). Dr. Paul is the senior physician at the Central Illinois Allergy and Respiratory Clinic. Those physicians specialize in allergy and pulmonary diseases. They take care of patients with respiratory diseases, critical care, allergic diseases and some internal medicine problems. Dr. Paul reads 15 to 20 chest x-rays per day (Petitioner's Exhibit 1, pp. 7-8). He also interprets about the same number of pulmonary function tests (Petitioner's Exhibit 1, p. 8). Dr. Paul is board certified in asthma, allergy and immunology (Petitioner's Exhibit 1, Deposition Exhibit 1).

At the request of Petitioner's counsel, Dr. Glennon Paul examined Petitioner on November 13, 2012 (Petitioner's Exhibit 1, p. 32; Deposition Exhibit 2). According to the history taken by Dr. Paul, Petitioner had shortness of breath for 10 years when going up two flights of stairs (Petitioner's Exhibit 1, p. 9). Dr. Paul was not aware at the time he examined Petitioner that he had applied for Social Security Disability. He was not aware of the reasons Petitioner gave for his disability to the Social Security Administration. Petitioner did not relate to Dr. Paul any triggers for his shortness of breath other than exertion. Petitioner did not relate cough or sputum to Dr. Paul (Petitioner's Exhibit 1, p. 33). Dr. Paul ordered pulmonary function testing which revealed a combination of obstructive airways disease and restrictive airways disease. Dr. Paul testified that these were both moderate. Petitioner's carbon monoxide diffusing capacity was moderately decreased. He had a negative methacholine stimulation test. Dr. Paul testified that same could imply that he did not have asthma because it did not get worse, but Petitioner was already pretty bad when the test was done (Petitioner's Exhibit 1, pp. 10-11).

Dr. Paul testified that based on all of the data available to him, Petitioner had coal workers' pneumoconiosis caused by inhalation of coal dust and the coal mine environment. Dr. Paul testified that the restrictive lung disease and obstructive lung disease were caused by the coal dust inhalation. Dr. Paul testified that Petitioner had decreased diffusing capacity caused by coal workers' pneumoconiosis (Petitioner's Exhibit 1, pp. 11-12). Dr. Paul testified that based on his diagnosis of coal workers' pneumoconiosis, restrictive lung disease, obstructive lung disease and diffusing capacity reduction, Petitioner could have no further exposure to the environment of a coal mine without endangering his health (Petitioner's Exhibit 1, p. 12). Dr. Paul testified that based on his pulmonary capacity, Petitioner could do light work (Petitioner's Exhibit 1, p. 14).

Dr. Paul testified that in order to have pneumoconiosis one must have, in addition to coal mine dust deposited in his lungs, a tissue reaction to it. That tissue reaction can be called scarring or fibrosis. Dr. Paul testified that by definition if one has coal workers' pneumoconiosis, he would have some impairment in the function of the lung at the site of the scarring whether it can be measured by spirometry or not (Petitioner's Exhibit 1, pp. 15-16).

At the time of Dr. Paul's physical examination of Petitioner, he had a BMI of 50.27 which was morbidly obese. Dr. Paul's physical examination of Petitioner's chest was normal. Petitioner did not tell Dr. Paul that he left mining at the time he did due to a respiratory disease or that he left mining at the time he did on the recommendation of a physician. Dr. Paul testified that Petitioner did not relate to him that he was unable to perform the duties of his last job in the coal mine (Petitioner's Exhibit 1, pp. 33-35). Dr. Paul testified that Petitioner did not relate to him ever having taken breathing medications. Dr. Paul did not ask him about breathing medications (Petitioner's Exhibit 1, p. 35). Dr. Paul testified that simple coal workers' pneumoconiosis can present itself asymptomatically. He testified that if one has symptoms, then he does not have simple coal workers' pneumoconiosis. Because Petitioner had symptoms and abnormal pulmonary function studies, he does not have simple coal workers' pneumoconiosis (Petitioner's Exhibit 1, pp. 35-36).

Dr. Paul did not know the date of the chest x-ray that he reviewed. He testified that the type of opacities present were fibronodular lesions throughout both lung fields (Petitioner's Exhibit 1, p.

36). Dr. Paul testified that his definition of profusion was not the concentration of small opacities in the affected lung zones (Petitioner's Exhibit 1, p. 37).

Dr. Henry K. Smith, a board certified radiologist and B-reader, interpreted a chest x-ray dated October 9, 2009, as positive for pneumoconiosis, profusion 1/0 with P/P opacities in all lung zones. Dr. Smith also interpreted a chest x-ray dated March 28, 2012, as positive for pneumoconiosis, profusion 1/0 with P/S opacities in the bilateral, middle and lower lung zones. Dr. Smith interpreted a CT of the chest with contrast dated January 11, 2010. He noted that same was performed with satisfactory technique in terms of slice thickness and interval between body sections for evaluation of coal workers' pneumoconiosis. Dr. Smith noted diffuse interstitial fibrosis with small opacities throughout the upper, mid and lower lung zones bilaterally of classification P/P and profusion 1/0 to 1/1 (Petitioner's Exhibit 2).

Records from NIOSH for the Coal Workers' Health Surveillance Program were admitted into evidence. A chest x-ray of August 28, 2002, was interpreted by two B-readers as negative for pneumoconiosis (Respondent's Exhibit 4).

At the direction of the Respondent, Dr. Cristopher Meyer reviewed chest x-rays of Petitioner dated October 9, 2009, and March 28, 2012. He also reviewed CT scans dated October 9, 2009, and January 11, 2010. Dr. Meyer testified that the chest x-ray of October 9, 2009, was quality 1. The chest x-ray of March 28, 2012, was quality 2 due to poor contrast and patient obesity. Dr. Meyer testified that the CT scans were of diagnostic quality (Respondent's Exhibit 1, pp. 41-42). Dr. Meyer found the x-ray of October 9, 2009, to be normal. The CT scan of the same date demonstrated several calcified nodules consistent with granulomatous disease. He testified that there was a nodule in the superior segment of the right lower lobe and a second one in the right middle lobe as well as several other individual nodules, but no findings of coal workers' pneumoconiosis and no lymphadenopathy. A follow up chest CT scan dated January 11, 2010, showed no findings of coal workers' pneumoconiosis. There was a one centimeter ground glass and solid nodule in the left lower lobe and a second nodule in the right upper lobe that were new when compared to the October, 2009, CT scan. Several other nodules seen on the previous examination had resolved. Dr. Meyer testified that there was a waxing and waning of several nodules that suggested an inflammatory process. Dr. Meyer testified that the chest x-ray of March 28, 2012, was normal (Respondent's Exhibit 1, pp. 42-43). Dr. Meyer testified that typically with coal workers' pneumoconiosis, once a coal macule has formed, one would not expect it to go away. He testified that the fact that the nodules had been present previously and then resolved would not be consistent with coal workers' pneumoconiosis. Also, the development of new nodules over that short time frame would not be typical of coal workers' pneumoconiosis even if Petitioner were still at the mine at that time (Respondent's Exhibit 1, p. 44).

Dr. Meyer has been board certified in radiology since 1992 (Respondent's Exhibit 1, p. 8). Dr. Meyer has been a B-reader since 1999 (Respondent's Exhibit 1, p. 21). Dr. Meyer was asked to take the B-reading exam by Dr. Jerome Wiot (Respondent's Exhibit 1, pp. 21-22). Dr. Wiot was part of the original committee that designed the training program which is called the B-reader program (Respondent's Exhibit 1, p. 23). Dr. Meyer has recently been asked to have a more active academic role with the B-reader program (Respondent's Exhibit 1, p. 33). Dr. Meyer

testified that radiologists have about a 10% higher pass rate on the B-reading exam than other specialties. In Dr. Meyer's opinion radiologists have a better sense of what the variation in normal is. Dr. Meyer testified that one of the most important parts of the B-reader training and examination is making a distinction between a 0/1 and 1/0 film (Respondent's Exhibit 1, pp. 35-36).

Dr. Meyer testified that the B-reader looks at the lung to decide whether there are any small nodular opacities or any linear opacities and based on the size and appearance of those small opacities, they are given a letter score (Respondent's Exhibit 1, pp. 23-24). Dr. Meyer testified that specific occupational lung diseases are described by specific opacity types. Coal workers' pneumoconiosis is characteristically described by small round opacities (Respondent's Exhibit 1, pp. 29-30). The distribution of opacities is also described because different pneumoconioses are seen in different regions of the lung. Coal workers' pneumoconiosis is typically an upper zone predominant process (Respondent's Exhibit 1, p. 24). The last component for interpretation is the extent of the lung involvement or the so-called profusion (Respondent's Exhibit 1, pp. 24-25). Dr. Meyer testified that the profusion is basically trying to define the density of the small opacities in the lung (Respondent's Exhibit 1, pp. 31-32). Dr. Meyer testified that nodular opacities would be the same as round. The term linear refers to irregular opacities (Respondent's Exhibit 1, p. 27).

Dr. Joseph J. Renn, III, is a medical doctor whose practice has been clinical, academic and consultative (Respondent's Exhibit 2, p. 2). In Dr. Renn's clinical practice he saw patients who had pulmonary and occupational lung diseases. Approximately one-third of the patients in his clinical practice were coal miners (Respondent's Exhibit 2, p. 3). Dr. Renn is a B-reader. He was first certified as a B-reader in 1981 and has been recertified continuously since that time (Respondent's Exhibit 2, p. 5). Dr. Renn is board certified in internal medicine, pulmonary disease and by the American College of Forensic Examiners and the Board of Forensic Medicine (Respondent's Exhibit 2, p. 6).

Dr. Renn was asked by Respondent's counsel to provide B-readings regarding chest x-rays dated August 28, 2002, and March 28, 2012. Counsel for Respondent provided the March 28, 2012, chest x-ray to Dr. Renn. The August 28, 2002, film was in the possession of NIOSH in Morgantown, West Virginia. This was a screening film that had been taken of Petitioner as part of the Coal Workers' X-ray Surveillance Program (Respondent's Exhibit 2, pp. 6-7).

Dr. Renn testified that the August 28, 2002, film was of marginal diagnostic quality. It was overexposed, and Petitioner had not taken a full breath so it was a somewhat dark film. The diaphragms were somewhat elevated (Respondent's Exhibit 2, p. 7). Dr. Renn testified that care has to be taken in interpretation of an overexposed film because an overexposed x-ray will make the infiltrates disappear. Dr. Renn testified that underinflation is significant in interpretation of a film because it will result in crowding of the lung bases and it will appear that there are linear opacities, when in reality, it is just failure to fully inflate the lung (Respondent's Exhibit 2, p. 8). Dr. Renn took the March 28, 2012, film with him to NIOSH in order to be able to make a side by side comparison with the August 28, 2002, film and the standard films (Respondent's Exhibit 2, pp. 10-11).

Dr. Renn testified that he could tell that Petitioner had lost some weight between 2002 and 2012. He could see a calcified granuloma in the right hilum on the 2002 film that he did not see on the 2012 film. Dr. Renn noted some apical thickening which had no clinical significance and was not related to dust exposure. Dr. Renn testified that neither of these films revealed the presence of pneumoconiosis (Respondent's Exhibit 2, p. 12).

Dr. Renn testified that with simple pneumoconiosis the opacities that one can see which are consistent with pneumoconiosis are less than one centimeter in diameter. With complicated pneumoconiosis the opacities are usually greater than a centimeter. Dr. Renn testified that the difference between simple and complicated pneumoconiosis has nothing to do with symptoms (Respondent's Exhibit 2, pp. 12-13). Dr. Renn testified that profusion is the density of the opacities, how many there are in a certain area. Dr. Renn testified that a proper interpretation of the film for pneumoconiosis requires a profusion rating (Respondent's Exhibit 2, pp. 13-14). Dr. Renn testified that a negative chest x-ray reading plus a sufficient history of exposure for coal workers' pneumoconiosis would not rule out pneumoconiosis in as much as the individual could have it on pathologic review (Respondent's Exhibit 2, p. 15). Dr. Renn testified that simple coal workers' pneumoconiosis is generally asymptomatic. Complicated pneumoconiosis with larger abnormalities would be more likely to be accompanied by symptoms and pulmonary function deficits (Respondent's Exhibit 2, p. 16).

At the request of Respondent's counsel, Dr. Jeffrey Selby examined Petitioner on July 18, 2013 (Respondent's Exhibit 3, pp. 7-8). Dr. Selby took a medical history and occupational history, conducted physical examination and laboratory testing and reviewed medical records (Respondent's Exhibit 3, p. 8). Dr. Selby has been board certified in internal medicine and pulmonary disease since 1980 and 1984, respectively (Respondent's Exhibit 3, p. 3). Dr. Selby has been a B-reader since 1985. Dr. Selby does general pulmonary work, both inpatient and outpatient. Dr. Selby testified a small percentage of his practice is in occupational lung disease. He sees and treats patients who have lung disease on a daily basis (Respondent's Exhibit 3, p. 4). Dr. Selby has occasion to see individuals who have the disease process coal workers' pneumoconiosis (Respondent's Exhibit 3, p. 5).

When asked what Petitioner related as his chief complaint, Dr. Selby stated that it was to "Do away with my diabetes and trouble breathing." Petitioner noticed that he was short of breath and wheezing more than in the past. He had a cough and expectorated about 50% of the time. The sputum was thick, yellow and green. He reported that he wheezed all of the time. He is able to walk about one quarter to one half mile before becoming so short of breath he had to rest. The most exertional activity he engages in is hooking and unhooking truck trailers. Petitioner tested positive for obstructive sleep apnea in 2007 but cannot tolerate his CPAP (Respondent's Exhibit 3, pp. 9-10). Petitioner never smoked cigarettes. He was exposed to second hand smoke from his mother for about 18 years, his first wife for 18 years and his current wife for the past 7 years. His current wife smokes occasionally in the house and in the car with the window slightly open (Respondent's Exhibit 3, pp. 11-12).

Dr. Selby testified that Petitioner's BMI was 55.6 which placed him out of the chart range for extreme obesity. Chest exam showed clear lungs with decreased breath sounds due to thick chest wall. Resting oxygen saturation on room air was 93%. Spirometry showed an FVC of 78% of

predicted, an FEV1 of 78% of predicted and an FEV1/FVC ratio of 80%. There was no improvement post bronchodilator. The total lung capacity was 71% of predicted and residual volume was 54% of predicted. Petitioner's diffusion capacity was 61% of predicted and when corrected for alveolar volume it increased to 111% predicted (Respondent's Exhibit 3, pp. 12-14). The interpretation was normal spirometry without change post bronchodilator. Lung volumes were normal with the exception of a residual volume that was low due to his extreme obesity. Petitioner's diffusion capacity was normal (Respondent's Exhibit 3, p. 14).

A chest x-ray performed on that same date was interpreted by Dr. Selby as being a quality 2 due to underinflation. He found no parenchymal or pleural abnormalities consistent with pneumoconiosis (Respondent's Exhibit 3, p. 14). Petitioner completed a six-minute walk test on room air. He walked 1,056 feet with no desaturation throughout the entire six minutes. He began to complain of dyspnea at minute three. His recovery pulse oximetry and heart were 95% and 85 beats per minute, respectively at five minutes post exercise. The study was consistent with normal exercise tolerance (Respondent's Exhibit 3, p. 14). Dr. Selby testified that Petitioner's diffusion capacity was low because his lung volume size was low. When corrected for the size of the lung, the diffusion capacity showed that the lung tissue was actually working very well (Respondent's Exhibit 3, pp. 15-16). Dr. Selby testified that Petitioner's massive obesity had an effect on his diffusion capacity. The protuberant, tight, obese belly was pushing up against the lung volumes reducing the actual size of the lung as measured. The belly is pushing up against the bottom of the lungs, which is the part of the lungs that does most of the work. If one is impairing the main motor and impairing the main gas exchange areas of the lung, it has a definite effect on breathing, dyspnea or shortness of breath on exertion, the size of the lungs and the raw diffusion capacity (Respondent's Exhibit 3, pp. 16-17). Dr. Selby also attributed the reduction of total lung capacity to Petitioner's body habitus (Respondent's Exhibit 3, pp. 17-18).

Dr. Selby testified that for a proper reading of a chest x-ray for pneumoconiosis, a good quality film with proper identification information on the film is required. He testified that it is important to have the date of the film. He testified that it is important to note the opacity type and mandatory to note what profusion is present. He testified that profusion means the concentration of small opacities in a given space. Dr. Selby testified that he cannot diagnose pulmonary impairment based upon a chest x-ray. He testified that the distinction between simple pneumoconiosis and complicated pneumoconiosis is based upon opacity size (Respondent's Exhibit 3, pp. 19-20). Dr. Selby testified that from a purely ventilatory standpoint, Petitioner was capable of heavy manual labor. In the testing that Dr. Selby performed there was no evidence of bronchospasm. There was no hyperactive airways disease such as asthma present (Respondent's Exhibit 3, p. 21). Dr. Selby testified that he reviewed the testing from Dr. Paul's examination. He testified that Dr. Paul's methacholine challenge on Petitioner was not valid. Based upon Dr. Paul's results, there was only a decline of three or four percent with methacholine. Dr. Selby testified that by anybody's standard that was a negative methacholine challenge test (Respondent's Exhibit 3, p. 22).

Dr. Selby concluded, based on all of the information available to him, that Petitioner does not suffer from any respiratory or pulmonary abnormality as a result of coal mine dust inhalation or coal mine employment. He does not suffer from coal workers' pneumoconiosis. Petitioner has very severe obesity which is causing his shortness of breath and exercise limitation. Dr. Selby

also testified that Petitioner's obese abdomen is crowding his lung bases where most of the gas exchange function of the lungs occur. Dr. Selby noted that Petitioner was deconditioned or "out of shape," leading to shortness of breath that he would not have if he was conditioned (Respondent's Exhibit 2, pp. 22-23). Dr. Selby noted that Petitioner had heart disease as noted on his EKG. He testified that this finding could indicate serious occult heart problems that could lead to shortness of breath (Respondent's Exhibit 3, pp. 23-24).

Dr. Selby testified that the tissue reaction of the coal dust in the lungs is called scarring or fibrosis. By definition, if a person has pneumoconiosis, he would necessarily have impairment in the function of his lung at the very site of the scarring whether that impairment could be measured by spirometry or not (Respondent's Exhibit 3, p. 33).

Dr. Selby reviewed chest x-rays dated October 9, 2009, and March 28, 2012. He did not find any abnormalities consistent with pneumoconiosis on these chest x-rays (Respondent's Exhibit 3, Deposition Exhibit 3). Dr. Selby testified that the quality of the chest x-ray is important as well as the date. He testified that the opacity type is important because it helps to determine what the causation might be (Respondent's Exhibit 3, p. 62).

Dr. Selby did not recall seeing any medication for airway problems, breathing problems or pulmonary problems in the medical records that he reviewed. He did not recall seeing any diagnosis for airways or pulmonary or respiratory disease in the medical records (Respondent's Exhibit 3, pp. 77-78).

Medical records of Illini Medical Associates were admitted into evidence. Physical examination of Petitioner's chest revealed no adventitious sounds on multiple examinations between August 3, 2001 and February 2, 2004 (Respondent's Exhibit 5, pp. 80-99). Petitioner was seen on April 15, 2004, at which time he related having a cold with his chest and head hurting. He also related a cough. Physical examination of the chest revealed the lungs to be clear bilaterally. The diagnosis on that date was acute bronchitis. Lungs were clear again on May 21, 2004, and August 24, 2004. In August 2004, Petitioner related some occasional sinus trouble (Respondent's Exhibit 5, pp. 75-77). Petitioner's lungs were found to be clear on January 21, 2005, and on subsequent examinations through February 10, 2006 (Respondent's Exhibit 5, pp. 44-64). Petitioner was seen on July 11, 2006, at which time it was charted that he felt he had sleep apnea (Respondent's Exhibit 5, p. 43). Petitioner was seen on September 11, 2006, with complaint of a chest cold. The assessment on that date was acute sinusitis and allergic rhinitis. Physical examination of the chest revealed the lungs to be clear to auscultation bilaterally (Respondent's Exhibit 5, p. 40). Physical examination of Petitioner's chest on August 7, 2007, revealed the lungs clear to auscultation bilaterally (Respondent's Exhibit 5, pp. 33, 35).

Petitioner was seen by Southern Illinois GI Specialists on February 11, 2008. In the review of systems respiratory, he denied shortness of breath on exertion, cough or cough with sputum. Physical examination of the chest on that date revealed the lungs clear bilaterally to auscultation (Respondent's Exhibit 5, pp. 174-175).

On May 12, 2008, Petitioner complained of cough with persistent drainage present for three to four days. The lungs were clear to auscultation bilaterally. Petitioner was diagnosed with upper

respiratory infection (Respondent's Exhibit 5, p. 29). Petitioner was seen on December 30, 2008, for complaints of pain in his right hip that radiated down his right leg. He had no other problems. Physical examination of the chest revealed the lungs clear to auscultation bilaterally (Respondent's Exhibit 5, p. 17). Petitioner was seen on September 24, 2010, with complaints of a non-productive cough and sneezing. It was also stated that he was going to file for disability before retiring in September 2011. The assessment was bronchitis, and Petitioner was prescribed a Z-pak (Respondent's Exhibit 5, p. 10). On June 24, 2011, August 10, 2011, August 17, 2011, and October 4, 2011, physical examination of Petitioner's chest revealed the lungs to be clear to auscultation bilaterally (Respondent's Exhibit 5, pp. 3-7).

Medical records of Memorial Medical Center were admitted into evidence. Petitioner underwent a CT scan on October 9, 2009. Same revealed an 8mm indeterminate pulmonary nodule or focal infiltrate in the left lower lobe which needed a three month follow up (Respondent's Exhibit 6, p. 70). Petitioner also underwent an x-ray of the chest on that same date. Granulomatous calcifications were seen. There was no acute disease (Respondent's Exhibit 6, p. 73).

Medical records of Midwest Occupational Health Associates were admitted into evidence. Petitioner was seen on January 13, 2011, to follow up on a back injury that occurred the week before. He had pain in the right lumbar region as well as a numbness to the right lateral thigh. He was diagnosed with a lumbar strain and he was given restrictions of no lifting over 20 pounds and no repetitive waist bending (Respondent's Exhibit 7, pp. 11-12).

Medical records of SIU HealthCare were admitted into evidence. Petitioner was first seen by Dr. Lanie Eagleton in the Division of Pulmonary and Critical Care Medicine on March 24, 2011. On that date Petitioner denied cough or mucous production. He related shortness of breath and walking a lot and ankles swelling when standing all day. In review of systems respiratory, Petitioner circled shortness of breath or wheezing (Respondent's Exhibit 8, pp. 37-39). Dr. Eagleton authored a letter to Dr. Swenie dated April 28, 2011, wherein he stated that Petitioner had obstructive sleep apnea, excessive daytime somnolence, insulin-dependent diabetes mellitus with neuropathy, obesity, arthritis and lumbosacral disc disease. Dr. Eagleton ordered oxygen two liters per minute by nasal cannula at home with a CPAP. He could walk greater than one block but it was limited by dyspnea (Respondent's Exhibit 8, pp. 25-26). Petitioner underwent pulmonary function testing on June 3, 2011. The indication for said testing was shortness of breath. Dr. Bakir stated that the baseline spirometry showed a mild obstruction, especially with small lung volume. With bronchodilator, Petitioner's spirometry improved consistent with a reversible component of his airway obstruction. His total lung capacity and his diffusion capacity were normal. Dr. Bakir's conclusion was that the testing was consistent with a mild airway obstruction (Respondent's Exhibit 8, p. 7). Petitioner was seen by Dr. Eagleton on July 12, 2011. He had mild dyspnea on exertion. He had no increase in cough or dyspnea secondary to respiratory problem. His O_2 saturation on room air was 97% (Respondent's Exhibit 8, pp. 2-3).

Medical records of Family Medical Center were admitted into evidence. Petitioner was first seen on January 18, 2010. On that date his weight was 268 pounds. Physical examination of the chest revealed the lungs to be clear (Respondent's Exhibit 9, pp. 65-66). Petitioner was seen on March 15, 2010, with sore throat, productive cough and some wheezing present for five to seven days. Physical examination of the chest revealed some crackles at the bases, right greater than left. The

assessment was upper respiratory infection/pneumonia (Respondent's Exhibit 9, p. 65). Petitioner was seen on August 9, 2010. At that time his weight was reported as 346 pounds. He had facial fullness, sore throat and runny nose. Physical examination of the chest revealed the lungs to be clear. The diagnosis was sinusitis (Respondent's Exhibit 9, p. 63). Petitioner was seen on September 14, 2012. Review of systems was negative except for polydipsia and polyphagia. On that date his weight was 353.12 pounds and his BMI was 54.1. His oxygen saturation was 95%. He had a normal respiratory rate and pattern (Respondent's Exhibit 9, pp. 48-49). Petitioner was seen for cold symptoms on January 14, 2013. An acute upper respiratory infection was noted which had been present for the past week. Symptoms included chest congestion, recent cough, ear congestion and stuffiness as well as nasal congestion and nasal discharge. His BMI was 55.3 on that date. Physical examination of the chest showed normal breath sounds with no rales, rhonchi, wheezes or rubs (Respondents' Exhibit 9, pp. 45-46). Petitioner was seen on October 4, 2013, for evaluation of diabetes with neurological manifestations. He had no recent cough, dyspnea or frequent wheezing. Physical examination was normal aside from his morbid obesity (Respondent's Exhibit 9, pp. 33-34). Petitioner was seen on March 27, 2014. Review of systems respiratory and cardiovascular were negative. Physical examination was completely negative aside from his morbid obesity. Physical examination respiratory showed normal breath sounds with no rales, rhonchi, wheezes or rubs (Respondent's Exhibit 9, pp. 25-26). Petitioner was seen on October 6, 2014, for follow up regarding his back pain. His O_2 saturation was 92% on room air. Physical examination respiratory showed normal respiratory rate and pattern with no distress (Respondent's Exhibit 9, pp. 12-13). Petitioner was seen on March 6, 2015, for Dr. Reyes to fill out a disability form. Review of systems respiratory was negative for cough, dyspnea and hemoptysis. Physical examination respiratory showed normal respiratory rate and pattern with no distress (Respondent's Exhibit 9, pp. 4-5).

Medical records of Prairie Cardiovascular Consultants were admitted into evidence. Petitioner was seen on December 17, 2010, upon referral of Dr. Swenie for diagnosis of shortness of breath. In history of present illness he noted that Petitioner had dyspnea on exertion for several years. He had a diagnosis of sleep apnea and had not been able to use CPAP due to claustrophobia. He had dyspnea on minimal exertion. Physical examination of the chest revealed the lungs to be clear to auscultation. The doctor's diagnoses were shortness of breath, hypertension, hyperlipidemia and diabetes. The doctor stated that Petitioner's dyspnea on exertion was likely multifactorial and related to his obesity, pulmonary hypertension and sleep apnea (Respondent's Exhibit 10, pp. 10-13).

Petitioner's Social Security Administration Disability file was admitted into evidence. Petitioner filed for Social Security Disability on January 19, 2012 (Respondent's Exhibit 11, p. 1). In the Disability Report – Adult, Petitioner listed the physical or mental conditions that limited his ability to work as back lumbar surgery, knee surgery on both, diabetes, neuropathy, sleep apnea and arthritis in shoulder. He indicated that he stopped working on January 4, 2012, because of these conditions (Respondent's Exhibit 11, pp. 15-31). The primary diagnosis on the Disability Determination and Transmittal was obesity with a secondary diagnosis being diabetes mellitus. Petitioner's claim for Social Security Disability was denied on the basis that he had the capacity for substantial gainful activity (Respondent's Exhibit 11, p. 1).

Conclusions of Law

In regard to disputed issues (C) and (F) the Arbitrator makes the following conclusions of law:

The Arbitrator concludes that Petitioner did not sustain an occupational disease arising out of and in the course of his employment for Respondent that manifested itself on January 3, 2012.

In support of this conclusion the Arbitrator notes the following:

Petitioner testified that he first noticed breathing problems at work in 2009. He would become short of breath and get exhausted more quickly and have to rest more. Petitioner was not taking any breathing medications at the time of trial. Petitioner testified that his breathing problems progressively got worse from the time he first noticed them until his last day of employment in the mine. Petitioner was performing his job duties in the coal mine up until his last day of employment with Respondent. The medical records revealed that Petitioner sustained an injury to his low back on January 3, 2011. Petitioner was given light duty restrictions and no lifting greater than 10 pounds and no repetitive waist bending as of January 6, 2011. These restrictions were increased to no lifting over 20 pounds as of January 13, 2011. Petitioner did not return to work in the coal mine but rather signed a resignation. Approximately a month after he left his employment with Respondent, Petitioner applied for Social Security Disability. He also applied for disability after he left Shawnee Express. In his applications for Social Security Disability he did not include black lung or other pulmonary disease as a basis for his disability. No doctor ever restricted Petitioner from working in the coal mines as a result of an occupational disease.

Dr. Glennon Paul testified that Petitioner suffered from a moderate restrictive lung disease with a reduced carbon monoxide diffusion capacity caused by his coal workers' pneumoconiosis. Petitioner's only pulmonary complaint when examined by Dr. Paul was that of exertional shortness of breath. The only trigger for Petitioner's shortness of breath related to Dr. Paul was exertion. Dr. Selby testified that at the time of his examination Petitioner was morbidly obese with a BMI of 55.6.

Dr. Selby attributed Petitioner's complaint of exertional dyspnea to his obesity and deconditioning. Petitioner did not suffer an impairment in pulmonary function. Dr. Selby testified that Petitioner did have a slightly reduced total lung capacity and diffusion capacity which he attributed to his obesity. Dr. Selby testified that the pulmonary function studies performed at Dr. Eagleton's lab on June 3, 2011, were normal.

Dr. Paul testified that he based the diagnosis of coal workers' pneumoconiosis upon the chest x-ray he reviewed. Dr. Paul, however, could not provide the date of the chest x-ray he reviewed. Also, he could not identify the opacity type present or what profusion the film had.

Dr. Meyer testified that in evaluating a chest x-ray for the presence of an occupational lung disease it is important to describe the type of opacities and the distribution of any opacities which are present.

Dr. Smith interpreted chest x-rays of October 9, 2009, and March 28, 2012, as positive for pneumoconiosis. Dr. Smith noted opacities in all lung zones on the 2009 chest x-ray and opacities only in the bilateral mid and lower lung zones on the 2012 chest x-ray. The opacities of coal workers' pneumoconiosis are permanent and will not regress on subsequent chest x-rays.

Dr. Meyer and Dr. Selby interpreted the chest x-rays of October, 2009, and March, 2012, as negative for coal workers' pneumoconiosis. Dr. Selby also interpreted chest x-ray of July 18, 2013, as negative for coal workers' pneumoconiosis.

Dr. Renn reviewed the original chest x-ray dated August 28, 2002, in a side by side comparison with the chest x-ray dated March 28, 2012. Dr. Renn testified that neither film revealed the presence of pneumoconiosis. The 2002 film was also interpreted by two NIOSH B-readers as negative for pneumoconiosis.

The Arbitrator finds the opinions of Dr. Selby, Dr. Meyer, Dr. Renn and the NIOSH B-readers to be more persuasive and credible than those of Dr. Paul and Dr. Smith.

In regard to disputed issues (L) and (O) the Arbitrator makes the following conclusions of law:

The Arbitrator makes no conclusions of law as these issues are rendered moot because of the Arbitrator's conclusion of law in disputed issues (C) and (F).

William R. Gallagher, Arbitrator

13WC21168
15WC04413
Page1

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

Michael Martin,
Petitioner,
vs.

NO: 13 WC 21168
15 WC 04413

City of Springfield,
Respondent,

17IWCC0026

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 9, 2016, is hereby affirmed and adopted.

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

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

The party commencing 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 2017
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DLG/mw
045

David L. Gore

Mario Basurto

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MARTIN, MICHAEL
Employee/Petitioner

Case# **13WC021168**
15WC004413

CITY OF SPRINGFIELD
Employer/Respondent

17IWCC0026

On 6/9/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.43% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0333 SHAY & ASSOCIATES
TIMOTHY M SHAY
1030 S DURKIN DR
SPRINGFIELD, IL 62704

0332 LIVINGSTONE MUELLER ET AL
DENNIS O'BRIEN
620 E EDWARDS PO BOX 335
SPRINGFIELD, IL 62705

17IWCC0026

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

Michael Martin
Employee/Petitioner

Case # **13** WC **021168**

v.

Consolidated cases: **15 WC 004413**

City of Springfield
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 **Springfield**, on **April 19, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **June 8, 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 conditions of ill-being are causally related to the accident.

In the year preceding the injury, Petitioner earned $**92,005.30**; the average weekly wage was $**1,769.34**.

On the date of accident, Petitioner was **53** years of age, married with **2** dependent children.

Petitioner has received all reasonable and necessary medical services.

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

Respondent shall be given a credit of $**17,776.50** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $17,776.50.

Respondent is entitled to a credit of $**19,092.15** under Section 8(j) of the Act.

ORDER

Medical benefits

Respondent shall pay reasonable and necessary medical services as set forth in Petitioner's Exhibit 14, directly to the providers, as provided in Section 8(a) and 8.2 of the Act.

Respondent shall receive a credit for medical bills paid by Health Alliance, and Respondent shall indemnify and hold Petitioner harmless for any bills for which is receive such credit, as provided in Section 8(j) of the Act.

Respondent shall reimburse Petitioner $688.96 for out of pocket medical expenses.

Temporary Total Disability

Respondent is ordered to pay Petitioner further temporary total disability benefits of $1,179.45 per week for a period of 5 and 1/7 weeks, commencing April 21, 2014 through May 27, 2014, as provided in Section 8(b) of the Act.

Permanent Partial Disability

Respondent shall pay Petitioner permanent partial disability benefits of $712.55/week for 75 weeks, because the injuries sustained to the right shoulder caused the 15% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

Respondent shall pay Petitioner additional permanent partial disability benefits of $712.55/week for 75.25 weeks, because the injuries sustained caused the 35% loss of the left leg, as provided in Section 8(e) of the Act.

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

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

Signature of Arbitrator

6/4/2016

Date

ICArbDec p. 2

JUN 9 - 2016

FINDINGS OF FACT

Petitioner is a fifty-six year-old high-school graduate who is retired from a nearly forty year career with the Respondent. Petitioner testified he began his employment with Respondent on June 8, 1977, one week after he graduated high school, and retired on July 3, 2014. He testified he spent his entire adult life working for Respondent. Petitioner testified that he worked as journeyman lineman and also as a troubleman, which required him to work primarily alone.

Petitioner testified that on June 8, 2013, he was called out to an outage near Winch Lane and Jefferson Street in Springfield. He was following an electrical line on foot through backyards and fences in order to see what had caused the fuse to blow and while looking up to inspect a transformer, tripped over a small tree stump, falling to the ground. Petitioner testified that he landed face first with his arms out. He testified that he spinned a little while falling and believed he twisted his knee. When he fell, he testified he felt a tearing sensation in his shoulder and a lot of pain. He testified that he got up and walked back to his truck, and as he was walking his knee began to hurt, but not as badly as his shoulder.

Petitioner immediately presented to Springfield Clinic's Prompt Care, and was evaluated by Dr. Kim Wyatt. PX 2. He complained of severe right shoulder pain and right wrist discomfort. PX 2. Petitioner noted that he had previously had surgery on his left shoulder for a labrum tear and that his right shoulder felt exactly the same as his left shoulder had. PX 2. He further reported that he had some pain in his left knee, which he thought he had twisted. PX 2. Dr. Wyatt requested a same-day consult with an orthopedist to evaluate Petitioner's right shoulder. PX 2.

Petitioner was shortly thereafter evaluated by Dr. Matthew Gardner, an orthopedic surgeon. PX 2. Petitioner reported his pain was ten out of ten when raising his arm and three out of ten when his arm was resting at its side. PX 2. Dr. Gardner performed a physical examination, but was unable to obtain a good range of motion assessment secondary to significant guarding of the right arm. PX 2. Petitioner exhibited a lot of pain with any internal or external rotation of the shoulder. PX 2. Dr. Gardner was further unable to test rotator cuff strength secondary to pain. PX 2. X-rays were taken of the right shoulder and reviewed, revealing no fracture or dislocation. PX 2. Upon Petitioner's request, Dr. Gardner referred him to Dr. Rodney Herron, another orthopedic surgeon, who had previously treated Petitioner for his left shoulder. PX 2.

On June 10, 2013, Petitioner presented to Dr. Rodney Herrin at the Orthopedic Center of Illinois for evaluation of his left shoulder. PX 3. Petitioner reported his work injury to Dr. Herrin. PX 3. Dr. Herrin reviewed the x-rays taken at Springfield Clinic, confirming no acute bony injuries, and attempted a physical examination, but found the shoulder was difficult to evaluate secondary to Petitioner's pain level. PX 3. Dr. Herrin provided Petitioner with a sling and recommended Petitioner perform range of motion exercises with the shoulder. PX 3. He further restricted Petitioner from work. PX 3.

Petitioner returned to Dr. Gardner on June 24, 2013. He testified that he returned to Dr. Gardner instead of continuing his treatment with Dr. Herrin because he was dissatisfied and uncomfortable with the office environment of Dr. Herrin's office. At Dr. Gardner's office, Petitioner reported his pain level was three out of ten. He had been taking Norco, which had made his pain tolerable. PX 2. He also complained of bilateral knee pain and left shoulder pain. PX 2. Dr. Gardner performed an examination of the right shoulder, which revealed pain and crepitation with range of motion. PX 2. Examination further showed pain and popping with impingement testing and minor pain with cross chest abduction, but not over the AC joint. PX 2. Both O'Brien and Speeds tests were positive and Petitioner demonstrated 4+/5 strength on all rotator cuff testing. PX 2. Dr. Gardner opined Petitioner's examination was consistent with a SLAP lesion and possible rotator cuff injury. PX

2. Dr. Gardner ordered an MR Arthrogram, and placed Petitioner off work until the arthrogram was completed. PX 2.

On July 3, 2013, Petitioner underwent an MR Arthrogram of the right shoulder at Springfield Clinic. PX 4. The arthrogram revealed partial-thickness tears of the supraspinatus and subscapularis tendons, infraspinatus and long head biceps tendinopathy, a tear of the superior labrum posterior to the biceps anchor, and osteoarthritis with joint hypertrophy at the AC joint with thickening of the coracoacromial ligament. PX 4.

Petitioner returned to Dr. Gardner on July 11, 2013 to review his arthrogram findings. He reported his shoulder was still very "achy" and that he had stopped taking hydrocodone as it was no longer providing much relief. PX 2. Examination revealed no change to his shoulder. PX 2. Dr. Gardner reviewed Petitioners Arthrogram and agreed with the radiologist's findings. PX 2. Dr. Gardner also obtained x-rays of the left knee, which revealed significant osteoarthritis. PX 2. Dr. Gardner referred Petitioner to Dr. Christopher Wottowa for further evaluation of the right shoulder and Dr. Tomasz Borowiecki for further evaluation of the left knee. PX 2. He further returned Petitioner to work with light duty restrictions. PX 2.

On July 24, 2013, Petitioner presented to Dr. Christopher Wottowa at Springfield Clinic. PX 2. He reported he had been injured at work when he tripped while walking through brush and landed on his right hand. PX 2. He reported he had felt a tearing in his right shoulder and had suffered consistent pain in the lateral aspect of his arm and shoulder since the fall. PX 2. Dr. Wottowa performed a physical examination, which showed a lot of guarding over the shoulder, but nearly full active range of motion. PX 2. Strength was difficult to assess secondary to guarding, but overall strength was 4-/5 in the impingement zone. PX 2. Dr. Wottowa reviewed Petitioners MR Arthrogram, noting an acute partial-thickness tear of the supraspinatus tendon, describing an area towards the anterior portion of the supraspinatus where there was edema in both the proximal humerus and the end of the tendon, but not complete tearing of the tendon. PX 2. Dr. Wottowa recommended Petitioner undergo an injection into the shoulder, which was performed in office, and that he perform supraspinatus strengthening exercises for four weeks. PX 2. Dr. Wottowa further recommended light duty restrictions of no lifting with the right arm greater than 5 pounds. PX 2.

On August 1, 2013, Petitioner presented to Dr. Tomasz Borowiecki for further evaluation of his left knee. PX 2. He reported he had been walking through a line of brush on June 8, 2013, got tangled in the brush and fell, sustaining an injury to his left knee. PX 2. Petitioner reported having prior problems with the left knee and undergoing a menisectomy and ACL repair in 1980, with occasional mild symptoms in the left knee since. PX 2. However, his symptoms had been more severe since the accident. PX 2. He reported his knee had been swelling, giving out when he moved or twisted, and he had trouble with stairs. PX 2. Petitioner had been treating with ice and Aleve without improvement. PX 2. Dr. Borowiecki performed a physical examination, which revealed the hips were non-tender to rotation, but when the left hip was rotated through the knee, it caused discomfort in the knee. PX 2. There was some laxity of the anterior cruciate ligament with the anterior drawer and Lachman's tests. PX 2. Further, there was medial joint line tenderness and crepitus in the patellofemoral joint. PX 2. Dr. Borowiecki reviewed the x-rays previously ordered by Dr. Gardner, and noted rather advanced osteoarthritis, marginal medial compartment, subchondral sclerosis, marginal osteophyte formation and evidence of prior surgery. PX 2. Dr. Borowiecki diagnosed degenerative arthritis of the knee with recent exacerbation/aggravation with constant symptoms secondary to injury on June 8, 2013. PX 2. Dr. Borowiecki noted that the arthritis was clearly not caused by the recent fall, but it appeared that the symptoms had been aggravated significantly by the accident. PX 2. He recommended Petitioner undergo a corticosteroid injection into the knee, which was performed in office, and further ordered physical therapy. PX 2. Dr. Borowiecki also expanded Petitioner's work restrictions to include limited standing, walking, kneeling, and squatting and no climbing. PX 2.

On August 14, 2013, Petitioner was seen by PA David Purves, a physician's assistant in the orthopedics department at Springfield Clinic who works under both Dr. Wottowa and Dr. Borowiecki. Petitioner noted that the cortisone injection performed by Dr. Borowiecki had already begun to wear off. PA Purves recommended Petitioner undergo a series of viscosuplementation injections in the left knee. PX 2. PA Purves performed the first of these injections in office. PX 2. With regards to the right shoulder, Petitioner noted he had not received significant relief from the injection and home exercise program. PX 2. He indicated he had received one week of relief from the injection. PX 2. Examination of the shoulder demonstrated reasonable motion but a lot of discomfort beyond 80 degrees of forward flexion and abduction. PX 2. He further had discomfort in the impingement zone and positive impingement signs. PX 2. He also had mild weakness at the supraspinatus. PX 2. PA Purves recommended Petitioner undergo a right shoulder arthroscopy as conservative measures had failed. PX 2. He continued Petitioners restrictions as to the right shoulder and amended his restrictions as to the left knee to no operating machinery, climbing, stooping, bending, or twisting, and no repetitive motion. PX 2.

Petitioner returned to PA Purves on August 21, 2013, for his second viscossupplementation injection, noting he had received some improvement to his symptoms with the first. PX 2. However, when he presented on August 28, 2013 for the third viscosupplementation injection, he noted that he did not get a lot of relief from the second injection and was continuing to have pain in the left knee. PX 2. The third injection in the series was given and Petitioner was instructed to follow up with Dr. Borowiecki in four to six weeks if no improvement. PX 2.

On August 26, 2013, Petitioner began physical therapy at Springfield Clinic with regards to his left knee. PX 6. He continued to receive physical therapy at Springfield Clinic until September 19, 2013. PX 6.

On September 9, 2013, at the request of the Respondent, Petitioner presented to Dr. Michael J. Milne of the Orthopedic Center of St. Louis for an Independent Medical Evaluation. Dr. Milne's report was entered into evidence as Petitioner's Exhibit 7. Petitioner reported that he was walking through some woods on June 8, 2013, chasing down a failed power line, when his foot was caught on a small tree stump and fell forward, initially feeling pain in his right shoulder. PX 7, p. 2. He further noted that as he walked back to his truck he began to have pain and swelling in his left knee. PX 7, p. 2. Petitioner reported having a history of left knee surgery in 1980 and 1981, with occasional pain and swelling thereafter. PX 7, p. 2. However, he reported after the accident his knee gives out if he walks more than three or four blocks and he will also have swelling. PX 7, p.2. He reported he had no prior injuries with regards to his right shoulder, but that he was not having pain at night, lack of range of motion, and a popping sensation. PX 7, p 2.

Dr. Milne examined Petitioner, noting tenderness over the biceps tendon and AC joint. PX 7, p. 3. Range of motion was limited as well, and there was pain noted with Speed's and O'Brien's testing. PX 7, p. 3. Examination of the left knee revealed slightly limited range of motion compared to the right. PX 7, p. 3. Petitioner was further quite tender over the medial joint line. PX 7, p. 3. Dr. Milne further reviewed Petitioner's prior radiological examinations, noting advanced degenerative changes on the knee x-ray taken July 11, 2013 and a high grade if not full thickness rotator cuff tear of the supraspinatus tendon, SLAP tear, and partial thickness subscapularis tear of the left shoulder on the MRI arthrogram taken July 3, 2013. PX 7, p. 3.

With regards to causation, Dr. Milne opined that, with regards to the right shoulder "it is pretty clear cut that this is a work related injury. His mechanism of injury makes sense and his MRI findings are consistent with it and his symptomology is consistent with it." PX 7, p. 4. As to the right knee, Dr. Milne opined "I believe his current work injury is an aggravation of that underlying condition and that underlying condition would be a post traumatic arthritis." PX 7, p. 4. With regards to treatment, Dr. Milne agreed that Petitioner required surgical

intervention for his shoulder. He recommended an arthroscopic rotator cuff repair, biceps tenotomy, and probably subacromial decompression, and clavical resection. PX 7, p. 4. With regards to the left knee, Dr. Milne recommended a partial verses full knee replacement, if Petitioner was not getting any symptom relief from conservative treatment. PX 7, p. 5.

On September 12, 2013, Petitioner returned to Dr. Borowiecki, for follow up regarding his left knee, noting the viscosupplementation series provided only short term relief. PX 2. Dr. Borowiecki noted only slight improvement to the left knee. Physical examination revealed trace effusion of the knee, crepitus, and tenderness in the patellofemoral and medial compartments. PX 2. There was also limited range of motion to the left knee. PX 2. At that time, Dr. Borowiecki recommended Petitioner undergo a total knee arthroplasty. PX 2. He further continued Petitioner's light duty restrictions as to his knee. PX 2.

Petitioner subsequently fell under the care of Dr. Paul Lux of the Orthopedic Center of St. Louis, upon referral by Dr. Milne, for treatment of his left knee. Petitioner was initially seen by Dr. Lux on November 14, 2013. PX 10. Petitioner reported having his foot caught on a small tree stump and twisting his left knee. PX 10. He noticed as he was walking back to his truck that his knee began to swell and his pain worsened over the next day. PX 10. He reported having a knee injury 20 years prior and that he had done well since with occasional soreness. PX 10. Dr. Lux performed an examination of the knee which showed some limitation in extension and 2+ effusion, as well as 3+ crepitus over the medial joint line with flexion and extension and 2+ patellofemoral crepitus. PX 10. He reviewed Petitioner's knee x-rays noting severe osteoarthritis with bone-on-bone contact medially in the patellofemoral joint. PX 10. He diagnosed severe osteoarthritis of the left knee. PX 10. Dr. Lux opined that Petitioner's "current symptoms and need for total knee replacement are causally connected to his work-related injury of June 8, 2013" and that his treatment had been appropriate. PX 10.

On April 1, 2014, Petitioner returned to the Orthopedic Center of St. Louis and was seen by both Dr. Lux and Dr. Milne, having chosen to undergo surgical intervention with both. PX 8, 10. Petitioner was first evaluated by Dr. Lux, at which time he noted his knee was causing him to limp constantly and that he was working half days. PX 10. Examination revealed reflexes only to 100 degrees and limited extension. PX 10. Petitioner exhibited pain both medially and in the patellofemoral joint. PX 10. Dr. Lux scheduled Petitioner for left total knee replacement on April 21, 2014. PX 10.

Petitioner was next evaluated by Dr. Milne, noting he wished to have his right shoulder surgery scheduled four weeks after his right total knee replacement. PX 8. Examination revealed tenderness over the biceps tendon and over the AC joint. He had limited range of motion and pain with Speed's and O'Brien's testing. PX 8. Dr. Milne noted that Petitioner's examination was unchanged from his previous evaluation and scheduled Petitioner's shoulder surgery. PX 8.

Petitioner underwent a total knee replacement with Dr. Lux at Barnes-Jewish hospital on April 21, 2014. PX 11. Interoperatively, the knee was found to have severe medial degenerative joint disease with defect and the undersurface of the patella was evaluated and had multiple osteophytes and grade III/IV changes. PX 11. Petitioner testified that he was placed off work after the total knee replacement and did not receive temporary total disability benefits from April 21, 2014 until May 27, 2014.

Petitioner returned to Dr. Lux for post-surgical follow-up on May 20, 2014. PX 10. Petitioner noted he had been struggling with pain, but that he had started outpatient physical therapy and was doing better. PX 10. Examination revealed minimally limited but improved range of motion to the knee. PX 10. Petitioner was instructed to continue physical therapy with a focus on range of motion and restricted from work. PX 10.

Petitioner was also seen by Dr. Milne on May 20, 2014. His shoulder examination was unchanged from April 1, 2014. Dr. Milne planned to move forward with shoulder arthroscopy, scheduling surgery for May 28, 2014. PX 8. He further continued Petitioner's light duty restrictions. PX 8.

On May 27, 2014, Petitioner underwent right shoulder surgery with Dr. Milne at the Emerson Road Surgery Center. PX 9. Dr. Milne performed a right shoulder arthroscopic revision subacromial decompression, revision rotator cuff debridement, subacromial decompression distal clavicle resection, rotator cuff, glenohumeral, labral, and biceps tendon debridement, and synovectomy. PX 9. Further, while Petitioner was anesthetized, he performed a non-surgical manipulation of the left knee. PX 9. Dr. Lux testified that he had asked Dr. Milne to perform the manipulation, which was simply bending the knee while under anesthesia, because it helps with rehabilitation of the knee. PX 13, p. 39. Dr. Lux testified he would not recommend a patient be placed under anesthesia simply for manipulation, but since Petitioner was going to be anesthetized for his shoulder arthroscopy, it would be beneficial to manipulate the knee. PX 13, p. 39. Intra-operative evaluation revealed the undersurface of the rotator cuff showed partial thickness tearing of the subscapularis, supraspinatus, and infraspinatus. The subscapularis showed partial tearing and damage. PX 9. The biceps tendon showed separation from the glenoid and damage to the anterior, superior, and posterior labrum. PX 9. The subscapularis showed partial thickening and tearing. PX 9. Further, he glenoid and humeral head cartilages showed grade II and III changes and there was moderate synovitis. PX 9. Dr. Milne rendered a post-operative diagnosis of right shoulder rotator cuff tear, right shoulder impingement syndrome, right shoulder acromioclavicular joint arthrosis, and right shoulder superior labral tear. PX 9.

On May 30, 2014, Petitioner began post-surgical physical therapy for his shoulder at St. John's Hospital. He continued to receive physical therapy until August 18, 2014. PX 12.

On June 17, 2014, Petitioner returned to Dr. Lux. He was continuing physical therapy and doing better, but still having a considerable amount of pain. PX 10. Dr. Lux performed a physical examination, noting full extension but continued limited flexion. PX 10. Dr. Lux recommended continued physical therapy and continued Petitioner's off work status. PX 10.

Petitioner also followed up with Dr. Milne on June 17, 2014. Petitioner reported he was doing well and had been attending physical therapy two times per week with positive results. PX 8. He was also regularly performing a home exercise program. PX 8. Dr. Milne noted that Petitioner was on light duty restrictions of no use of the right arm and use of a sling at all times. PX 8. Examination showed mild effusion to the right shoulder will full passive range of motion with pain at the end of range. PX 8. Dr. Milne instructed Petitioner to continue physical therapy, discontinue his sling, and continued his work restrictions. PX 8.

On July 8, 2014, Petitioner returned to Dr. Lux for follow up for his knee replacement. PX 10. Petitioner's flexion had continued to improve on physical examination, but he was continuing to have significant pain. PX 10. Dr. Lux continued Petitioner's physical therapy to work on range of motion and kept him off work. PX 10. Petitioner also presented to Dr. Milne on July 8, 2014, at which time he was instructed to continue physical therapy and home exercise and his restrictions were amended to 15 pounds of lifting with the right arm. PX 8.

Petitioner was discharged from physical therapy for his shoulder on August 18, 2014. He reported soreness with certain overhead movements and pain at a level of four on a ten point scale with motion. Measurements showed slight restrictions when compared with the uninjured shoulder, along with a strength loss. He was found to have met the majority of his therapy goals. (PX 12)

Petitioner returned to Dr. Milne on August 19, 2014. He reported he was continuing to do better, but was having some occasional pain and weakness in the shoulder. PX 8. He was continuing to undergo physical therapy. PX 8. Physical examination was essentially normal. PX 8. Dr. Milne discontinued Petitioner's physical therapy, but instructed him to continue his home exercise program. PX 8. He was released to return to work without restrictions for the shoulder. PX 8.

On September 30, 2014, Petitioner returned to Dr. Milne for his final follow- up visit. PX 8. He reported he was feeling pretty well, but was having some discomfort and pain with motions above the head and was still having trouble lying on the right side. PX 8. Petitioner was trying to perform his home exercises twice per day. PX 8. Examination revealed near full active range of motion and strength the same as the injured shoulder.. PX 8. Dr. Milne opined there was no additional need for treatment and placed Petitioner at maximum medical improvement. PX 8.

On May 1, 2015, Petitioner returned to Dr. Lux for a one year follow-up for his total knee replacement. PX 10. Petitioner reported his preoperative pain was gone and that he had returned to part-time work. PX 10. Dr. Lux performed a physical examination and obtained x-rays, which showed all surgical components remained in their proper place. He had previously noted the Petitioner achieving full knee extension, and now had flexion to 115 degrees, an improvement over the 110 degrees seen at his visit on July 8, 2014. PX 10. Dr. Lux released Petitioner from care without restrictions. PX 10.

Prior to his June 8, 2013 work accident, Petitioner had previously treated with Dr. Morton in 2006 to 2008 for bilateral leg weakness. RX 4. During his treatment with Dr. Morton, he reported general weakness in the legs. PX 4. In November 2006, Petitioner was evaluated by Dr. Cecil Becker, a neurologist, and underwent an EMG study of his lower extremities, which was normal. RX 4. Beginning in August 2007 and continuing through June 2008, Petitioner treated with Dr. Morton for discomfort in his right knee, for which he was sent to physical therapy, and was ultimately sent for evaluation by a Dr. Michael Pick, a rheumatologist. RX 4. Although Petitioner did have findings consistent with osteoarthritis of the left knee during his 2007-2008 treatment with Dr. Morton, he had no complaints of left knee pain or discomfort. RX 4. When Petitioner initially presented to Dr. Pick on May 7, 2008, he complained of right knee pain and discomfort. Again, Petitioner made no complaints regarding his left knee. RX 4.

Petitioner returned to Dr. Morton on May 2, 2013 complaining of all over joint pain. RX 4. Petitioner noted that the pain had come and gone for years, but that it was at its most painful. RX 4. Petitioner explained that one joint would bother him for a time, and then it would move to another joint. On May 2, 2013, his hands were particularly bothering him. RX 4. Dr. Morton referred Petitioner back to Dr. Pick. RX 4.

When Petitioner returned to Dr. Pick on June 3, 2013, five days prior to the work accident, Petitioner noted problems with his shoulders, hips, and left knee. RX 4. He described his ongoing muscle joint pain as "weakness." He stated that the weakness symptoms seemed to come and go and would move about his body. RX 4. Petitioner was ultimately diagnosed with polymyalgia rheumatic, an inflammatory disorder. RX 4.

Petitioner testified that the complaints he was having in his left knee on June 3, 2013 were different than after his accident. He testified "it was just a kind of a nagging pain that would - - like I said went from my knee - - one knee to the other knee to shoulders to hips, and mainly my hips."

Petitioner continued to receive treatment from Dr. Pick after his work accident for his polymyalgia rheumatic. RX 4. On July 12, 2013, Dr. Pick noted that Petitioner's aches and pains were "markedly improved." However, he continued to have "pain in the right shoulder," which an MRI had shown evidence of tendinopathy

within the supraspinatus and subscapularis, and pain within the left knee with osteoarthritis, with examination showing tenderness within the left knee. RX 4.

Dr. Lux testified via his evidence deposition, which was entered into evidence as Petitioner's Exhibit 13. Dr. Lux is a board certified orthopedic surgeon who exclusively treats patients who are candidates for hip and knee replacements. PX 13, p. 6. He testified he performs 350 knee replacements in a given year. PX 13, p. 6. Dr. Lux testified that, it was his understanding that Petitioner had sustained a work related injury 20 years prior to his June 8, 2013 accident, which required an open meniscectomy followed by an anterior cruciate ligament reconstruction of the left knee. PX 13, p. 8. He further testified that it was his understanding that Petitioner had unrestricted activity and his knee would get sore from time to time. PX 13, p. 8. However, following the June 8, 2013 accident, Petitioner's knee hurt all the time and caused him to limp. PX 13, p. 8.

Lux had reviewed Dr. Morton's medical record of May 2, 2013 and Dr. Pick's record of June 3, 2013, noting that Petitioner complained of multiple joint pains and denied any mechanical problems, such as locking, giving out, catching, and swelling. PX 13, pp. 9-10. Rather, Petitioner had reported to Dr. Morton and Dr. Pick that he had pain and stiffness in his hands, knees, and shoulders. PX 13, p. 10. Dr. Lux testified that when he evaluated the Petitioner, he noted crepitus in the left knee, which he testified is a mechanical finding and was not present in the May 2, 2013 or June 3, 2013 examinations. He further testified that he found effusion, or swelling, of the joint which was not noted in the two earlier notes. Dr. Lux testified that the fact that the May 2, 2013 and June 3, 2013 records were devoid of any mechanical left knee complaints indicated "he was not having the type of symptoms he complained of when I saw him." PX 13, p. 11.

Dr. Lux testified that it was his opinion that the Petitioner's symptoms and need for the total knee replacement were causally connected to his work-related injury of June 8, 2013. PX 13, p. 17. He testified that Petitioner had some aches and pains prior to the accident, but he had aches and pains all over his body that his rheumatologist was treating him for. PX 13, p. 18. However, "the type of problem [the Petitioner] was having to his knee was clearly different following this injury." PX 13, p. 18. Dr. Lux testified that he had questioned Petitioner repeatedly as to whether he had missed any work previously because of his knee and he had not. PX 13, p. 18. After the accident, he could not work at all, and his knee was sore and swollen. PX 13, p. 18. "Clearly something has changed." PX 13, p. 18.

Dr. Lux testified that Petitioner was a candidate for a total knee replacement because he had failed conservative treatment, the x-ray of his knee showed he was bone-on-bone, and he was in severe pain. PX 13, p. 18. He testified the total knee replacement was reasonable and necessary. PX 13, p. 21.

Dr. Lux testified that although Petitioner had a severely arthritic knee, he would not be able to predict whether or not Petitioner would be in pain simply based on the level of degeneration PX 13, pp. 31-32. He testified that although someone has an arthritic knee, he may not have severe symptoms. PX 13, p. 32.

On February 20, 2014, Petitioner was evaluated by Dr. Brian Cole, a board certified orthopedic surgeon who testified he does not perform knee replacements for an Independent Medical Evaluation at the request of the Respondent. Dr. Cole's evidence deposition is entered into evidence as Respondent's Exhibit 1. With regards to Petitioner's left knee, Dr. Cole opined that he did not believe that the injury changed the natural course of the need for treatment of his left knee. RX 1, p. 12. He based his opinion, in part, on the fact that Petitioner already had ongoing treatment for osteoarthritis prior to the injury. RX 1, p. 12. However, Dr. Cole testified that if Petitioner had ongoing symptoms, the accident would be an aggravation, "but I can't tell incrementally how much more aggravated it was." RX 1, p. 13. He testified that the symptoms to the knee continued during the period immediately after the accident. RX 1, p. 13.

Dr. Cole was asked about the May 2, 2013 note visit with Dr. Morton and the June 2, 2013 office note of Dr. Pick. Of note, Dr. Cole did not have those records in his file for Petitioner. RX 1, p. 18. Dr. Pick agreed that on May 2, 2013, Petitioner had presented to Dr. Morton for multiple joint pain, specifically for his hands, and that Petitioner's diagnosis of polymyalgia rheumatic could cause multiple joint pain as explained on this date. RX 1, p. 19. He further agreed that Dr. Morton did not note any mechanical symptoms or any swelling. Rx 1, p. 19. He noted that there was nothing in that particular note that pointed towards any condition of the left knee warranting a total knee replacement. RX 1, p. 20.

Turning to the June 3, 2013 office note of Dr. Pick, he testified that he was not able to determine if Dr. Pick had indicated any mechanical findings or swelling to Petitioner's knee. RX 1, p. 21. He testified that Petitioner had reported pain with his shoulders, his left knee, and his hips. RX 1, p. 21. Dr. Cole testified that Dr. Pick, in fact, did not say anything specifically about the Petitioner's left knee warranting any sort of treatment. RX 1, p. 21. Dr. Cole agreed that, if Petitioner had mechanical symptoms after the accident with swelling and increased pain, that would change Petitioner's treatment options as to his left knee. RX 1, p. 23.

Dr. Cole testified that, with regards to the pain Petitioner presented with to Dr. Pick, he was unable to differentiate the pain between osteoarthritic pain and rheumatoid arthritis pain. RX 1, pp. 40-41. Dr. Cole did agreed that a total knee replacement was reasonable and necessary treatment for Petitioner's left knee condition, and that the treatment up until the evaluation had been appropriate. RX 1, p. 14-15

With regards to the Petitioner's right shoulder, Dr. Cole agreed that "at the lowest level" the accident was "an aggravation of a preexisting condition" and that it was causally related to the work accident. RX 1, p. 13. He further agreed that shoulder arthroscopy with rotator cuff repair was the appropriate treatment for Petitioner's injury and that all treatment up to the evaluation had been appropriate. RX 1, p. 14-15. Dr. Cole testified, after reviewing Dr. Lux's Deposition Exhibit 2 (PX 1), that Petitioner would not be capable of full duty work, due to his requirement to climb ladders and work overhead. RX 1, p. 16.

Dr. Lawrence Li performed an impairment rating on Petitioner on January 11, 2016. Dr. Li's evidence deposition is entered into evidence as Respondent's Exhibit 2. Dr. Li performed impairment ratings of Petitioner's left knee and right shoulder, according to the AMA Guidelines 6th Edition. With regards to the right shoulder, Dr. Li testified that, even though there were multiple diagnoses rendered by Dr. Milne post-surgically, he was only allowed to rate one condition per the Guidelines. RX 2, pp. 13-14. Dr. Li chose to rate the diagnosis of labral tear as it would grant the greatest impairment. RX 2, p. 14. Dr. Li testified that the other diagnoses were considered with regards to the clinical studies grade modifier, giving a grade modifier of 4, because there was rotator cuff pathology in addition to labral pathology. RX 2, pp. 14-15. Dr. Li testified Petitioner continued to have occasional pain in his right shoulder related to raising his arm, which he rated as a three out of ten. RX 2, pp, 17-18. He also continued to have stiffness and aching in the shoulder. RX 2, p. 18. Dr. Li testified that Petitioner's complaints in his shoulder will likely be permanent. RX 2, pp. 18-19.

For the right shoulder rating, Dr. Li used the diagnosis of labral lesion, and placed Petitioner in Class 1, because he had residual symptoms, consistent objective findings and/or functional loss with normal motion. RX 2, p. 22. He testified that was the highest class he could place Petitioner in for an upper extremity injury to the shoulder. RX. 2, p. 22. The default class C rating was 3% loss of the upper extremity. Petitioner's functional history modifier was 1, and no modification was made. RX 2, p. 23. The physical examination modifier was also 1, because Petitioner exhibited a slight loss of motion, which was also a net of zero. The clinical studies grade modifier was a 4, based on the multiple pathologies, which pushed Petitioner to the top of his bracket at 5% loss of the upper extremity. RX 2, p. 24.

With regards to the left knee, Dr. Li agreed that there was a second procedure performed to the knee, a manipulation under anesthesia, and that the Guidelines did not take that procedure into consideration in rating impairment. RX 2, pp. 16-17. Petitioner exhibited five degrees of limited extension and 25 degrees of limited flexion, which Dr. Li agreed would be permanent and was not unusually for a total knee replacement. RX 2, p. 19. Petitioner also had some atrophy of the quadriceps muscle, which would be related to the surgery. RX 2, p. 19. Dr. Li placed Petitioner in Class 2, because he had moderate problems, but basically a good result. RX 2, p. 30. The physical exam grade modifier was -1 because of his loss of motion. RX 2, p. 31. He was given a negative grade modifier, despite significant loss in motion, because of the higher class. RX 2, p. 31. In order to have a neutral grade modifier, Petitioner would have had to have had a limp with shortening of the legs and used either a cane or crutch. RX 2, p. 32. Petitioner was given a lower extremity impairment of 21%. RX 2, p. 34.

Petitioner testified that he retired from his employment with Respondent on July 3, 2014. Since his retirement, he has taken a couple of auto repair courses at Lincoln Land Community College, but testified that he took those classes for fun, because he enjoys working on automobiles. He testified he has not been employed to perform any auto body work since taking those courses. Petitioner has also held a few post-retirement jobs in the construction field. He testified that he worked for Asplundh Line Construction for approximately three months putting up routers, which he described as little electric boxes on the end of a short street light arm. He testified he assembled the routers on the ground and placed them on the arm from a bucket truck. He testified that the work bothered his right shoulder, but he could perform the job. He testified that he stopped working for Asplundh because it was too hard, it got too cold, and the work was repetitive. He was also concerned with slipping on the ice due to his knee.

Petitioner testified he also worked for L.E. Meyers Construction for approximately a month and a half in the fall of 2015, operating a pot-holer machine, which is used to dig holes. He testified that his knee would get stiff performing this job. He also stopped working for L.E. Meyers in the winter.

Petitioner testified that he is unable to climb poles with his knee replacement. He also testified he is unable to reach out and pull with his shoulder like he could before. He continues to have pain in the center of the left knee, mainly when he sits for a while and gets up to walk. He described the pain as dull and that is comes and goes. He testified that he rides his bicycle everyday to help with the knee pain. He testified that he is unable to straighten his knee all the way and cannot bend it as much. He also testified that he limps a bit and has weakness when he tries to climb stairs. Petitioner also continues to have some pain in the center of his right shoulder. He testified he has a sharp pain with reaching and pulling. He further testified the shoulder is not as strong as it used to be. He sometimes has trouble getting his belt through the back loop. Petitioner testified that he has trouble riding his motorcycle due to the need to have his arms outstretched and his knee bent.

CONCLUSIONS OF LAW

As to Issue F, is the current condition of Petitioner's left knee causally related to the injury, the Arbitrator finds as follows:

After a review of the totality of the evidence, the Arbitrator finds that the current condition of the Petitioner's left knee is causally related to the June 8, 2013 accident. The Arbitrator relies primarily on the testimony of Dr. Lux and an evaluation of Petitioner's medical records in rendering his decision. The Respondent presented nearly ten years of prior medical records into evidence documenting Petitioner's ongoing aches and pains. Of note, the only mention of any left knee pain, from 2006 to the date of accident was during

the June 3, 2013 office visit with Dr. Pick. Petitioner had presented to Dr. Morton the month prior, complaining of all over joint pain, after seeking no medical treatment for any of his joints for a period of five years. RX 4. When Petitioner presented to Dr. Morton, he was primarily having difficulties with his hands, but indicated the pain moved from joint to joint. RX 4. When Petitioner presented to Dr. Pick on June 3, 2013, he complained not only of pain to his left knee, but also pain in his bilateral shoulders and hips, that would move about his body. RX 4. Further, Petitioner testified that the complaints he was having on June 3, 2013 were a "nagging pain" that would move from joint to joint and was "mainly" in his hips. The records further reflect that Petitioner has polymyalgia rheumatic, which Dr. Cole testified could be causing the wandering joint pain. RX 1, p. 19.

All of the physicians who have given evidence have agreed that there was nothing in Dr. Pick's June 8, 2013 evaluation the lead to a particular pathology of the left knee as causing Petitioner's problems, and there certainly were not mechanical findings and effusion that Petitioner presented with after the June 8, 2013 accident. In fact, Dr. Lux testified that the May 2, 2013 and June 3, 2013 records were devoid of any mechanical left knee complaints, which indicated to him that Petitioner was not having the symptoms he complained of when he presented to Dr. Lux. PX 13, p. 11.

Dr. Lux opined that Petitioner's symptoms and need for total knee replacement were caused by his work injury of June 8, 2013. PX 13, p. 17. This opinion is supported by the opinions of Dr. Borowiecki and Dr. Milne, both of whom were aware of Petitioner's pre-existing degenerative knee condition at the time they rendered their opinions. PX 2; PX 7, p. 4. It was Dr. Lux's opinion that prior to the accident Petitioner had multiple aches and pains all over his body that would come and go, but after the accident Petitioner's knee was clearly different. PX 13, p. 18. Further, Dr. Lux significantly focused on the fact that prior to this accident Petitioner had no problem working on his knee; however, after the accident, he was placed on work restrictions and had severe pain. PX 13, p. 18. Even Dr. Cole agreed that Petitioner would not have been able to work prior based on the condition of his knee prior to his surgery. RX 1, p. 16.

While it is more than clear that Petitioner had a severely degenerative knee, and was having aches and pains all over his body due to his polymyalgia rheumatic, it is also clear that the pain complaints Petitioner made to Dr. Pick on June 3, 2013 regarding his left knee are altogether different than those Petitioner made after his June 8, 2013 accident, which culminated in the need for his total knee replacement. Therefore, the Arbitrator finds that the current condition of Petitioner's knee is causally related to his work accident of June 3, 2013.

As to Issue J, where the medical serves provided to Petitioner reasonable and necessary and has Respondent paid all appropriate charges for reasonable and necessary medical services, the Arbitrator finds as follows:

The Arbitrator finds, that as the current condition of Petitioner's left knee is causally related to the work accident of June 8, 2013, and that all physicians involved agreed that Petitioner's treatment has been reasonable and necessary, that the medical services provided to Petitioner are reasonable and necessary and that the Respondent has not paid for all appropriate charges for reasonable and necessary medical services.

The Petitioner's related medical bills are set forth Petitioner's Exhibit 14. Respondent shall pay the Petitioner's medical bills as set forth in Petitioner's Exhibit 14, directly to the providers, according to the fee schedule, as set forth in Section 8(a) of the Act. The Respondent shall receive a credit pursuant to Section 8(j) of the Act for all medical bills paid by its group health insurer, Health Alliance and the Respondent shall indemnify and hold Petitioner harmless for any bills for which it receives such credit. Additionally, Petitioner has paid $688.96 out of pocket towards his medical expenses. The Respondent is ordered to reimburse the Petitioner in the amount of $688.96 for out of pocket medical expenses.

As to Issue K, temporary total disability benefits, the Arbitrator finds as follows:

The period of temporary total disability in dispute is the period between Petitioner's total knee replacement and his shoulder arthroscopy. There is no dispute that Petitioner was temporarily and totally disabled during this period of time. Because the Arbitrator finds that the Petitioners condition to his left knee is causally related to his accident, and that condition precipitated the need for surgery, the Arbitrator finds that the Petitioner was temporarily and totally disabled from April 21, 2014 to May 27, 2014 as a result of his work related injury.

Respondent is ordered to pay Petitioner temporary total disability benefits of $1,179.45 per week for a period of 5 and 1/7 weeks, commencing April 21, 2014 through May 27, 2014, as provided in Section 8(b) of the Act.

As to Issue L, what is the nature and extent of the injury, the Arbitrator finds as follows:

For accidents occurring after September 1, 2011, the Arbitrator must look to the five factor test in determining permanent partial disability. The first factor is impairment rating according to the AMA Guidelines 6th Edition. In this case, an AMA Guidelines rating was performed by Dr. Lawrence Li giving an impairment rating of 5% of the upper extremity for the right shoulder and 21% of the lower extremity for the left knee. The Arbitrator first notes that impairment does not equal disability and that disability encompasses more than impairment. As to the upper extremity, the Arbitrator notes that Dr. Milne rendered four post-operative diagnoses, but by virtue of the rules of the Guidelines, an impairment may only be rendered as to one of those diagnoses. As to the knee, the Arbitrator notes that the Petitioner's significant limitation in range of motion actually managed to decrease is impairment rating. For the above stated reasons, the Arbitrator gives this factor some weight.

As to the second factor, nature of the employment, the Petitioner worked for the Respondent in a rather physical job for his entire adult life. However, Petitioner took a planned retirement prior to completing his medical treatment. Evidence was presented at trial that Petitioner had been planning his retirement since prior to his date of accident. For this reason, the Arbitrator give this factor no weight.

With regards to the third factor, age, the Petitioner was 53 years old on the date of his accident, and is currently 56. The Petitioner has retired, but will likely live for a number of years and continue to suffer his permanent limitations, as set forth in factor five, during that period. As such, the Arbitrator places some weight on this factor.

With regards to the fourth factor, future earning capacity, Petitioner has retired and planned to do so prior to the date of accident. However, Petitioner testified that he has attempted other jobs in a construction type environment. He has testified that he is not comfortable working outside in ice and snow due to the condition to his leg. Further, he testified he experienced discomfort in his right shoulder during one of his jobs. It does appear that Petitioner left his two prior jobs, at least in part due to his concerns regarding his physical condition. Arbitrator gives this factor some weight.

Finally, with regards to the fifth factor, evidence of disability corroborated by treatment records, Petitioner testified he continues to have pain in the left shoulder and it is not as strong as before. He is unable to

reach out and pull with his shoulder like he could before. He sometimes has trouble looping his back belt loop. He continues to have pain in the center of the left knee, that he described as dull and occasional. He is unable to straighten his knee and cannot bend it much. He further has trouble riding his motorcycle.

At his last office visit with Dr. Milne, Petitioner reported he was continuing to have some discomfort and pain with motions above the head, as well as trouble lying on the right side. He was found on examination to have normal strength and near full active ranges of motion. PX 8. Petitioner continued to have similar complaints when he was evaluated by Dr. Li for his AMA Guidelines review, at which time Dr. Li testified such symptoms would likely be permanent. RX 2, pp. 18-19. Dr. Li further noted five degrees of limited extension and 25 degrees of limited flexion of the left knee, which he testified would be permanent. RX 2, p. 19. The Arbitrator places great weight on this factor.

Taking the evidence and the five factors into consideration, the Arbitrator finds that Petitioner has sustained a 15% loss of the person as a whole with regards to Petitioner's right shoulder as a result of the June 8, 2013 accident. Respondent is ordered to pay Petitioner $712.55 per week for a period of 75 weeks. The Arbitrator further finds that the Petitioner has sustained a 35% loss of the left lower extremity as a result of the June 8, 2013 accident. The Respondent is ordered to pay Petitioner an additional $712.55 per week for a period of 75.25 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 up	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Daniel Silva,

Petitioner,

vs.

NO: 13 WC 42509

Artists Frame Service,

Respondent.

17IWCC0027

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

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

- Petitioner is a 43 year old employee of Respondent, who described his job as a picture frame maker. Petitioner stated that Respondent makes wooden frames, specialized frames. Petitioner testified that he previously just made frames but now he moves boxes around and carries molding. Petitioner stated that he was continuously moving his wrist and arm. On the date of accident, June 3, 2013, Petitioner testified that he experienced pain in his right arm at his elbow while he was making the frame. Petitioner stated that he felt his arm going to sleep, like ants (paresthesia). Petitioner testified that after that it hurt a lot and he told his supervisor that he no longer had strength in his arm and hand. Petitioner is right hand dominant.

- Petitioner testified that he was sent to Ergo Medica by Respondent and eventually that

clinic referred him to Midwest Orthopedics at Rush where he was provided a series of injections to his right elbow Petitioner stated that he had physical therapy at Athletico. Petitioner sought another opinion with Dr. Blair Rhode who performed surgery on Petitioner's right elbow on April 1, 2014. Petitioner was eventually released from Dr. Rhode's care on or about September 25, 2014; he was unclear of the date. Petitioner returned to work at Respondent doing the same job and different types of additional duties. Petitioner testified that he received a quarter more per hour just prior to this hearing. He is still working the same hours.

- Petitioner testified that currently he cannot hit very hard with the hammer as his elbow hurts when he uses the hammer. Petitioner testified that with changes in the weather, temperature, his arm also hurts. Petitioner testified that he notices the pain on both sides (inside and outside) of his elbow; however, when the accident first occurred the pain was on the outside area of the right elbow. Petitioner testified that the elbow, inside area of the elbow, started hurting when they got rid of the pain on the outside area. It was not after the surgery. Petitioner stated that therapy had taken away some of the pain that was at the outside area, but he still did not have the strength, so it started hurting at the inside area; the inside area pain started when he was in therapy.

The Commission finds that only lateral epicondyle pain complaints are noted in the medical records until months later, but still the only diagnosis was 'right lateral epicondylitis'; medial complaints were noted with certain movements, but nothing significant and medial complaints were not even consistently noted and there was no treatment indicated or directed to any medial epicondylitis. There were some medial complaints noted with therapy (and with certain activities) but it was not to an extent of being considered an injury during that treatment. There are no medical causal opinions by treating doctors regarding medial epicondylitis. Respondent's §12 examiner indicated causal relationship to the lateral epicondylitis but not to a medial epicondyle condition. Petitioner's testimony is unrebutted and evidence supports a finding that Petitioner proved a causal connection regarding the lateral epicondylitis, but not to any medial epicondylitis. The Commission finds the decision of the Arbitrator as not contrary to the weight of the evidence. And, herein, affirms and adopts the Arbitrator's finding as to causal connection- (again we emphasize, as to right lateral epicondylitis only).

The Commission further finds, with the finding above of causal relationship to the lateral epicondylitis condition, that the testimony and evidence supports the finding that the medical bills are reasonable and necessary regarding that treatment. The Commission finds the decision of the Arbitrator as not contrary to the weight of the evidence, and, herein, affirms and adopts the Arbitrator's finding as to medical expenses.

The Commission, with the above finding of causal relationship, further finds that Petitioner's ongoing complaints in regard to the lateral epicondylitis are supported in the treating records. The Commission acknowledges Respondent's AMA rating indicated little residual impairment. The evidence and Petitioner's unrebutted testimony, however, supports a slightly higher permanent partial disability (PPD) award given the initial conservative care and ultimate release with some atrophy and weakness and ongoing complaints to an increase of the PPD award to

12.5% loss of use of the arm with that being consistent with Commission decisions of a similar nature. The Commission finds the decision of the Arbitrator, while not totally contrary to the weight of the evidence, is slightly insufficient given the preponderance of the unrebutted testimony and evidence, and herein, modifies to increase the PPD award to find a loss of 12.5% loss of use of the right arm

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $330.00 per week for a period of 31.625 weeks,-(total PPD=$10,436.25) as provided in §8(e)(10) of the Act, for the reason that the injuries sustained caused the 12.5% loss of use of Petitioner's right arm.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay for medical expenses under §8(a) of the Act for the medical care rendered for Petitioner's right lateral epicondylitis as being found reasonable and necessary and awarded. Medical care rendered for right medial epicondylitis was not reasonable or necessary and is hereby denied, as found by the Arbitrator. The Commission further orders Respondent to pay the medical bills per the Act, Fee schedule. Respondent shall be given credit for amounts paid towards medical bills including under §8(j) and shall hold Petitioner harmless for all medical bills paid via group carrier.

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 $12,000.00. 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 0 2017
o-12/15/16
DLG/jsf
045

David S. Gore
David Gore

Stephen J. Mathis
Stephen Mathis

Mario Basurto

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SILVA, DANIEL
Employee/Petitioner

Case# **13WC042509**

ARTISTS FRAME SERVICE
Employer/Respondent

17IWCC0027

On 3/18/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.51% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0147 CULLEN HASKINS NICHOLSON ET AL
JOSE M RIVERO
10 S LASALLE ST SUITE 1250
CHICAGO, IL 60603

2837 LAW OFFICE JOSEPH A MARCINIAK
JAMES J MIRRO
TWO N LASALLE ST SUITE 2510
CHICAGO, IL 60602

17IWCC0027

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

STATE OF ILLINOIS)
)
COUNTY OF COOK)

ILLINOIS WORKERS' COMPENSATION COMMISSION

ARBITRATION DECISION

DANIEL SILVA
Employee/Petitioner

Case #13 WC 42509

V.

ARTIST FRAME SERVICE
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 29, 2016. After reviewing all of the issues, the stipulations of the parties and the evidence, it is hereby found and ordered as follows:

ISSUES:

A. ☐ Was the respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?

B. ☐ Was there an employee-employer relationship?

C. ☐ Did an accident occur that arose out of and in the course of the petitioner's employment by the respondent?

D. ☐ What was the date of the accident?

E. ☐ Was timely notice of the accident given to the respondent?

F. ☒ Is the petitioner's present condition of ill-being causally related to the injury?

G. ☐ What were the petitioner's earnings?

H. ☐ What was the petitioner's age at the time of the accident?

I. ☐ What was the petitioner's marital status at the time of the accident?

J. ☒ Were the medical services that were provided to petitioner reasonable and necessary?

K. ☐ What temporary benefits are due: ☐ TPD ☐ Maintenance ☐ TTD?

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

M. ☐ Should penalties or fees be imposed upon the respondent?

N. ☐ Is the respondent due any credit?

O. ☐ Prospective medical care?

FINDINGS

- On June 3, 2013, the respondent was operating under and subject to the provisions of the Act.
- On this date, an employee-employer relationship existed between the petitioner and respondent.
- On this date, the petitioner sustained injuries that arose out of and in the course of employment.
- Timely notice of this accident was given to the respondent.
- In the year preceding the injury, the petitioner earned $23,068.76; the average weekly wage was $443.63.
- At the time of injury, the petitioner was 43 years of age, married with three children under 18.
- The petitioner agreed that the respondent paid $5,468.57 in temporary total disability benefits.
- The respondent agreed that the petitioner is entitled to temporary total disability benefits for 16-4/7 weeks, from April 3, 2014, through July 27, 2014.

ORDER:

- The respondent shall pay the petitioner the sum of $330.00/week for a further period of 20.24 weeks, as provided in Section 8(e) of the Act, because the injuries sustained caused the permanent partial disability to petitioner to the extent of 8% loss of use of his right arm.
- The respondent shall pay the petitioner compensation that has accrued from June 3, 2013, through February 29, 2016, and shall pay the remainder of the award, if any, in weekly payments.

- The medical care rendered the petitioner for his right lateral epicondylitis was reasonable and necessary and is awarded. The medical care rendered the petitioner for his right medial epicondylitis was not reasonable or necessary and is denied. The respondent shall pay the medical bills in accordance with the Act, the medical fee schedule or any prior adjustments or negotiated rate. The respondent shall be given credit for any amount it paid toward the medical bills, including any amount paid within the provisions of Section 8(j) of the Act and shall hold the petitioner harmless for all the medical bills paid by its group health insurance carrier.

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

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

Robert E. Williams

Signature of Arbitrator

March 18, 2016

Date

MAR 18 2016

FINDINGS OF FACTS:

The petitioner, a right-handed picture-frame maker, sustained an injury to his right elbow while making frames on June 3, 2013. He sought care at ErgoMedica, whose assessment was right lateral epicondylitis, tenosynovitis and arm pain. He had therapy and followed up several times a week through September 27, 2013. He received a right lateral epicondylar injection from Dr. Fernandez on August 18, 2013, which provided some improvement in his pain. A right elbow MRI on September 19, 2013, revealed mild to moderate common extensor tendinosis and a degenerative cyst at his capitellum.

The petitioner began care with Dr. Jeffrey Mjaanes on October 8, 2013, and reported pain on the lateral aspect of his right elbow, pain radiating toward his wrist and weakness in his wrist. Dr. Mjaanes noted tenderness to palpation over the petitioner's lateral epicondyle but no tenderness over the medial epicondyle or olecranon process. He diagnosed right lateral epicondylitis, for which he provided a platelet-rich plasma right lateral epicondylar injection. The petitioner reported some improvement on October 22nd. He started physical therapy on October 29, 2013. On December 17, 2013, the petitioner reported no improvement and pain over the medial aspect of his elbow. He reported doing better on January 10, 2014, and eccentric strengthening was prescribed by Dr. Mjaanes.

The petitioner sawc Dr. Blair Rhode on March 13, 2014, who noted that pain was elicited at the right lateral epicondyle. On April 1st, Dr. Rhode reformed a right elbow open lateral epicondyle release and medial epicondyle injection. At his last post-op follow-up with Dr. Rhode on September 25th, the petitioner reported mild ring and little

finger numbness and the exam elicited pain at the lateral epicondyle. He was given a full-duty work status.

FINDING REGARDING WHETHER THE MEDICAL SERVICES PROVIDED TO PETITIONER ARE REASONABLE AND NECESSARY:

The medical care rendered the petitioner for his right lateral epicondylitis was reasonable and necessary and is awarded. The medical care rendered the petitioner for his right medial epicondylitis was not reasonable or necessary and is denied.

FINDING REGARDING WHETHER THE PETITIONER'S PRESENT CONDITION OF ILL-BEING IS CAUSALLY RELATED TO THE INJURY:

Based upon the testimony and the evidence submitted, the petitioner proved that the current condition of ill-being with his right lateral epicondylitis is causally related to the work injury.

FINDING REGARDING THE NATURE AND EXTENT OF INJURY:

The AMA impairment rating by Dr. Coe was 4% of an arm. There was no evidence concerning the impact of the petitioner's injury in regard to his occupation, age or future earning capacity, as delineated in Section 8.1(b)(ii) through (iv) of the Act, nor can any effect or weight be reasonably inferred. Regarding Section 8.1(b)(v), the petitioner complains of a little pain on the inside and outside of his right arm that increases with weather and the inability to hit as hard with a hammer. The final treating records noted complaints of mild ring and little finger numbness and pain at the lateral epicondyle. The weight given Section 8.1(b)(v) is 4% loss of use of the right arm.

The respondent shall pay the petitioner the sum of $330.00/week for a further period of 20.24 weeks, as provided in Section 8(e) of the Act, because the injuries

sustained caused the permanent partial disability to petitioner to the extent of 8% loss of use of his right arm.

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

Marion White,

Petitioner,

vs.

NO. 14WC 25026

17IWCC0028

Pleasant Hill CUSD #3,

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 and temporary disability/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 March 28, 2016 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Commencing on the second July 15th after the entry of this award, the petitioner may become eligible for cost-of-living adjustments, paid by the ***Rate Adjustment Fund***, as provided in Section 8(g) of the Act.

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.

17IWCC0028

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 0 2017
SJM/sj
o-12/8/2016
44

Stephen J. Mathis

Mario Basurto

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WHITE, MARION
Employee/Petitioner

Case# **14WC025026**

PLEASANT HILL CUSD #3
Employer/Respondent

17IWCC0028

On 3/28/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.44% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2934 BOSHARDY LAW OFFICE PC
JOHN BOSHARDY
1610 S 6TH ST
SPRINGFIELD, IL 62703

5739 WHITT LAW LLC
BRIAN P WOJCICKI
70 S CONSTUTION DR
AURORA, IL 60505

17IWCC0028

STATE OF ILLINOIS)
)
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

Marion White
Employee/Petitioner

Case # 14 WC 25026

v.

Pleasant Hill CUSD #3
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 Quincy, on March 3, 2016. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

B. ☐ Was there an employee-employer relationship?

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

D. ☐ What was the date of the accident?

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

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

G. ☐ What were Petitioner's earnings?

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

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

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

K. ☐ What temporary benefits are in dispute?
☐ TPD ☒ Maintenance ☒ TTD

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

M. ☐ Should penalties or fees be imposed upon Respondent?

N. ☐ Is Respondent due any credit?

O. ☐ Other _____

FINDINGS

On **October 23, 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 $ **26,616.72** ; the average weekly wage was $ **511.86** .

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

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

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

Respondent shall be given a credit for $**15,697.04** for TTD, $**0** for TPD, $**6,824.80** for maintenance, and $**0** for other benefits, for a total credit of $**22,521.84**.

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $ **341.24**/week for **122 & 5/7** weeks, commencing **October 25, 2013** through September 11, 2014, and maintenance benefits for 76 6/7 weeks, commencing September 12, 2014 through March 3, 2016,, as provided in Section 8(a) of the Act.

Respondent shall pay Petitioner permanent total disability benefits of $ **499.20**/week for life commencing March 4, 2016, because the injuries sustained caused **Petitoner to become permanently and totally disabled** as provided in Section 8(f) of the Act.

Respondent shall pay Petitioner compensation that has accrued from **October 23, 2013** through **March 3, 2016** , and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall pay $ **5,052.50** for medical services, as provided in Section 8(a) and 8.2 of the Act. Respondent is entitled to credit for any actual related medical expenses paid by any group 8(j) health provider and Respondent is to hold Petitioner harmless for any claims for reimbursement from said group health insurance provider and shall provide payment information to Petitioner relative to any credit due. Respondent is to pay unpaid balances with regard to said medical expenses directly to Petitioner. Respondent shall pay any unpaid, related medical expenses according to the fee schedule and shall provide documentation with regard to said fee schedule payment calculations 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.

17IWCC0028

D. Dylan McEntee

3/23/2016

Signature of arbitrator

Date

MAR 2 8 2016

Marion White vs. Pleasant Hill C.U.S.D. #3
IWCC No. 14 WC 25026

First of all, the Arbitrator notes that there was an objection raised to Respondent's Exhibit 7, and the ruling was reserved pending foundation testimony. The Arbitrator failed to formally rule at the end of said testimony, but did indicate to the parties during the course of trial that the report would be admitted. In order to clear up any confusion, the report is hereby admitted into evidence.

In support of the Arbitrator's findings on the issue of **(J) Were the medical services that were provided to the petitioner reasonable and necessary?**, the Arbitrator finds the following facts:

The findings of fact stated in other parts of this decision are adopted and incorporated by reference here.

The parties stipulated that all medical expenses submitted as Petitioner's exhibit 13 were reasonable and necessary and that Respondent would pay the medical expenses as follows, pursuant to the Fee Schedule:

Mefford Chiropractic Center, 10/25/13-1/31/14	$2,640.50
Hannibal Clinic, 2/24/14-3/19/14	$1,552.00
Chiropractic & Auriculotherapy Center, 10/28/13-12/23/13	$ 860.00
Total:	**$5,052.50**

Respondent is entitled to credit for any actual related medical expenses paid by any group 8(j) health provider and Respondent is to hold Petitioner harmless for any claims for reimbursement from said group health insurance provider and shall provide payment information to Petitioner relative to any credit due. Respondent shall pay any unpaid, related medical expenses according to the fee schedule and shall provide documentation with regard to said fee schedule payment calculations to Petitioner.

In support of the Arbitrator's findings on the issue of **(K) What amount of compensation is due for Temporary Total Disability?**, the Arbitrator finds the following facts:

The findings of fact stated in other parts of this decision are adopted and incorporated by reference here.

The parties stipulated that Petitioner was temporarily and totally disabled from October 25, 2013 through September 11, 1024, and entitled to maintenance benefits from September 12, 2014 through February 23, 2015. Respondent terminated Petitoner's maintenance benefits as of February 25, 2015 for no stated reason other than Respondent's vocational expert was of the opinion that the vocational rehabilitation planning enabled Petitioner to locate suitable work in his labor market. As noted in other parts of this decision, Respondent offered no evidence to show that a reasonably stable labor market existed within which Petitioner could locate suitable employment.

Petitioner continued to perform a diligent, yet unsuccessful, job search after vocational assistance in the form of "vocational rehabilitation planning" was terminated.

The Arbitrator finds that Petitioner was entitled to maintenance benefits from February 26, 2015 through the date of arbitration, March 3, 2016.

In support of the Arbitrator's findings on the issue of **(L). What is the nature and extent of the injury?** the Arbitrator finds the following facts:

The findings of fact stated in other parts of this decision are adopted and incorporated by reference here.

Petitioner testified credibly.

Petitioner and Respondent stipulated that Petitioner sustained an accident injury to his cervical spine on October 23, 2013 which caused the condition of ill-being that is the subject of this claim.

Petitioner developed left sided pain that radiated from the left side of his neck from the ear down his left arm and into his left hand. Petitioner came under the care of Dr. Rahul Basho who diagnosed Petitioner with central and left paracentral disc osteophyte complex with sever spinal canal narrowing. (PX 4) Chiropractic care and a left sided C8 selective nerve root injection failed to relieve his symptoms and Petitioner elected to proceed with surgery. (PX 4) Respondent authorized Petitioner's surgery.

An IME was scheduled and performed on December 11, 2013 but Respondent did not offer the report into evidence. (RX 3)

Petitioner underwent a C7-T1 anterior cervical discectomy and fusion on February 6, 2014. (PX 4, 8) Immediately after surgery Petitioner developed difficulty speaking, and clawing of his left small, ring and index finger and a tremor in his left hand. While in the hospital Petitioner was referred to Dr. Justin Imhoff for evaluation of his "hoarseness". (PX 8)

Petitioner underwent laryngoscopy which confirmed he sustained right true vocal cord paralysis. (PX 9) Petitioner declined further treatment but did accept referral to Dr. Randal Paniello of the Washington University School of Medicine. (PX 9, 11) Dr. Paniello confirmed the diagnosis of right true vocal cord paralysis but Petitioner advised Dr. Paniello that he preferred to avoid intervention. (PX 11) An EMG of Petitioner's vocal cord was performed on August 18, 2014 which confirmed a chronic right laryngeal nerve injury. (PX 11) As of August 18, 2014 Dr. Paniello felt it was unlikely Petitioner would experience additional recovery. (PX 11)

Petitioner noted the surgery reduced his arm pain somewhat. After surgery Petitioner underwent physical therapy. On May 8, 2014 Petitioner was seen by Dr. Basho where it was noted that while in therapy Petitioner had a "setback" while on a ball a therapist pulled his arms back and he began to experience increased neck and left arm pain. (PX 4) Dr. Basho discontinued the physical therapy. Dr. Basho released Petitioner to sedentary work and Petitioner asked the Respondent's Superintendent of Schools if he could return to work. It was unrebutted that no light duty work was offered. (PX 4)

On June 5, 2014 Dr. Basho noted that Petitioner had recurrence of pain with activity and ordered a functional capacity evaluation. (PX 4)

A functional capacity evaluation was performed on July 7, 2014. (PX 12) The FCE indicated that Petitioner could safely lift 7 to 8 pounds constantly, 18 to 23 pounds frequently and 36 to 45 pounds occasionally. (PX 4, 12) The FCE indicated the Petitioner could perform in the medium physical demand category. (PX 12)

On July 10, 2014 Dr. Basho issued permanent work restrictions based on the FCE and added that Petitioner could perform neither overhead work nor work with vibratory tools. (PX 4) Petitioner was released from Dr. Basho's care on September 11, 2014. (PX 4)

Petitioner requested that Respondent allow him to return to work within the restrictions issued by Dr. Basho but no position was offered. (PX 15)

A Section 12 examination was performed on November 26, 2014 by Dr. Paul Matz. (RX 3) Dr. Matz noted Petitioner's symptoms at that time included left hand numbness, cramping in his fingers and clawing of his left hand, in which his fourth and fifth digits clawed forward and the remainder did not. (RX 3) Dr. Matz also noted that Petitioner had severe left arm pain when he extended his head back. Petitioner also had neck pain from his ear down to his shoulder and weakness in his left hand. (RX 3) Dr. Matz also noted permanent hoarseness. (RX 3)

On examination Dr. Matz noted Spurling's sing was positive for left arm pain, positive Tinel's sign at the left elbow which caused hand numbness, reduced arm strength on the left with testing, diminished sensation in the left 4th and 5th digits and an intention tremor bilaterally but more predominant on the left. RX 3)

Dr. Matz diagnosed Petitioner as having, among other conditions, a cervical neck pain due to cervico-genic disc disease not improved after cervical discectomy and arthrodesis, raising the possibility of pseudo arthrosis. (RX 3) Dr. Matz felt the Petitioner's ongoing symptoms were consistent with his objective findings. (RX 3) Dr. Matz felt the intention tremor was probably underlying but the weakness in his left arm increased the intention tremor. (RX 3)

Dr. Matz did not recommend a second FCE and felt the treatment had been reasonable and necessary. (RX 3) Dr. Matz however felt the Petitioner had not reached maximum medical improvement and recommended a cervical MRI, plain x-rays to determine if Petitioner had a pseudo arthrosis and an EMG/nerve conduction velocity study. (RX 3) Finally, Dr. Matz felt Petitioner should have work restrictions consistent with the FCE. (RX 3) No further testing was performed.

Petitioner continues to have stiffness in his neck, and rotation to the left is extremely painful. Petitioner continues to have pain extending down to the shoulder and left arm. Petitioner notices that reaching and lifting as little as a cup of coffee increases his pain. Petitioner has tremors in his left hand which comes and goes depending on activity. Petitioner continues to have hoarseness in his voice and a tremor in his left hand. Petitioner continues to have a clubbing of his fifth and fourth left fingers and his middle finger bends slightly downward. Petitioner notices his left hand is cold.

On October 15, 2014 Petitioner began a self-directed job search and requested vocational rehabilitation from Respondent. (PX 14) The Petitioner lives in Pleasant Hill, Illinois which is 90 miles from Springfield, Illinois, 50 to 55 miles from Jacksonville, Illinois, and 55 miles from

Quincy, Illinois and 50 miles from Hannibal, Illinois. It takes Petitioner more than an hour to drive to those locations. Petitioner described that the area between Pleasant Hill and those cities is largely rural and Pittsfield, Illinois is 22 miles from his home.

Petitioner obtained his position with the Respondent as a result of an advertisement in the newspaper and when his brother, the head of maintenance for the Respondent at the time, told Petitioner to apply. Prior to his employment by Respondent, Petitioner worked for the City of Pleasant Hill for two years in the street maintenance department. Before then Petitioner worked for Titan Wheel in Qunicy through Adecco Employment Agency for three months before being laid off. Prior to his employment at Titan Wheel Petitioner worked for Ketterman's Dish Service installing dish network TVs in Pittsfield, Illinois.

Petitioner is 58 years old and has a high school degree. Petitioner also has a few semesters of junior college education from more than 30 years before but he received no degree.

Petitioner conducted his job search by networking with friends, using the newspaper, the internet, Illinois Job Search Match, by telephoning prospective employers and by applying directly at potential employers' places of business. Petitioner did not inform any of the prospective employers of his restrictions when he applied. Not all of the employers he contacted would take an application if they were not hiring. Petitioner would ask if he could leave his application or resume and was often refused.

Respondent hired vocational counselor Julie Bose of MedVoc Rehabilitation, LTD. Julie Bose owns MedVoc Rehabilitation, LTD. and testified at arbitration. Bose conducted an Initial Vocational Rehabilitation Evaluation Report after meeting with Petitioner on December 5, 2014. (RX 4) Petitioner stated the meeting lasted an hour. Bose claimed to have conducted a transferability of skills assessment, however a later report issued and signed by Bose, and her employee, Lauren Egl dated February 23, 2014, indicated that Petitioner was asked to complete a 'transferability of skills assessment' on January 27, 2015. (RX. 5, p.2)

After meeting with Petitioner Bose felt that Petitioner was not conducting an "appropriate" or "effective" job search. Bose did not indicate what aspects of Petitioner's job search was inappropriate other than to note that Petitioner had not been using the internet and that every employer he had contacted was not hiring.

Bose concluded based on her evaluation that Petitioner was employable as a "light van driver, unarmed security officer, janitorial supply clerk, or construction building material sales

clerk". (RX 4) Bose did not offer any evidence that such work existed on a continuous basis in Petitioner's labor market.

Bose testified that she recommended that Petitioner be provided with placement services. Instead, Respondent and MedVoc performed a "Vocational Rehabilitation Planning" assignment in which an employee of MedVoc, Laruen Egl, a "job placement specialist" met with Petitioner and performed limited activities. (RX 5) Bose testified that Egl had no degree in vocational rehabilitation but instead had a 'marketing' degree.

Petitioner met with Egl three times. A report of the meetings was admitted as Respondent's Exhibit 5 and indicates the meetings took place on January 27, 2015, February 3, 2015 and February 19, 2015. (RX 5) Petitioner testified that when meeting with Egl she crossed out a number of items on a list that indicated the services MedVoc would not be performing. (PX 18) Petitioner acknowledged that included in the list were services that MedVoc did perform such as creating a resume, reviewing and approving a practice application, conducting a mock interview and performing a typing test that indicated the Petitioner could type 14 words per minute. (RX 5) The report of February 23, 2015 issued and signed by Bose indicates that Petitioner completed the sample application and the mock interview professionally and appropriately.

Egl and Petitioner reviewed how to apply for employment online on February 19, 2015 and together they located and completed one application for an appropriate employer, Per Mar Security. Petitioner testified that prior to this time he had applied for employment with DOT Foods, Inc. online.

In its report of February 23, 2015 Bose and Egl indicated that MedVoc had provided "full vocational planning services" to Petitioner and that as of that time "petitioner has the knowledge and experience to look for work in an appropriate and professional manner". (RX 5)

Apart from the Per Mar job, neither Respondent nor MedVoc provided Petitioner with any other job leads throughout Petitioner's entire job search.

Bose testified vocational services were terminated after Petitioner's last meeting with Egl on February 19, 2015, despite Bose's opinion that she felt Petitioner required further placement services. Neither MedVoc nor Respondent provided any further vocational placement services to Petitioner and Respondent terminated Petitioner's maintenance benefits on February 23, 2015.

Petitioner stated that his maintenance benefits were terminated as of February 23, 2015. Bose admitted the fact that Petitioner's maintenance benefits were terminated would make it harder for Petitioner to look for work.

Petitioner testified that he did try to contact Egl to obtain additional job search forms after their last meeting but he received no further forms or contact from MedVoc. Egl had left on maternity leave. Petitioner continued his job search on his own using forms provided by his attorney.

Petitioner had several interviews with prospective employers. Petitioner interviewed at Mash, a retail sales store. The position was not offered to Petitioner because as it was an appliance store, even in sales he would be expected to move appliances occasionally and this would be precluded by his permanent restrictions. The prospective employer declined to alter the job to accommodate the restriction.

Petitioner had an interview with Dot Foods, Inc. in Mt. Sterling, Illinois, approximately an hour from his home. Petitioner obtained this job lead on his own from Illinois Job Search at the unemployment office. Petitioner had a phone interview for an opening in the packaging department picking and packing boxes weighing 50 to 100 pounds. The Petitioner was told the job was not within his restrictions and he did ask if there could be an accommodation but there was nothing that could be offered to Petitioner.

Petitioner interviewed with Kay's Furniture for a part time positon for delivering and going to St. Louis for auctions. Petitioner was unaware of the position that he was applying for when he applied and had applied for any openings. Kay's did not hire Petitioner.

Petitioner interviewed for a position with Eagle Business Products for a sales and delivery job which involved moving desks and furniture. Petitioner's restrictions could not be accommodated by Eagle business.

Petitioner also applied at Ayerco gas station and Quick Stop as a sales clerk and cashier. Petitioner stated that even the cashier positon required that he be responsible for stocking shelves and the lifting would exceed his restrictions.

Petitioner interviewed for a position with Leslie's Hallmark which also operated as a US Cellular telephone company. Petitioner stated that the job was lighter duty but he was not hired. Petitioner was not hired and felt he was not because of his voice and was told that they needed someone who customers could better understand.

Bose issued a final report dated February 8, 2016 in which she was also critical of Petitioner's job search efforts and claimed that Petitioner did not perform a valid job search because he "targeted" employers that were not hiring, did not utilize the internet sufficiently, and did not leave an application or resume with prospective employers. Bose acknowledged that many employers might refuse to take an application if the employer was not hiring.

At Petitioner's counsel's request, Jim Ragains, a Certified Vocational Counselor employed by Hines & Associates, met with Petitioner on February 17 2015. (PX 17) Ragains conducted a full vocational rehabilitation assessment and the report of his opinions were offered into evidence as PX 17.

Ragains reviewed Petitioner's medical records, correspondence and reports from MedVoc, Petitioner's job search records and resume. (PX 17) Ragains interviewed Petitioner to obtain his educational background and work history. Ragains noted Petitioner had a high school degree, junior college classes in the early 1990's and other than a keyboarding class, no formal training for use of a personal computer or keyboard. (PX 17) Ragains noted, and Petitioner testified, that his internet service was interrupted as of the date of his meeting with Ragains because his limited finances caused the loss of his internet services. Ragains noted that Petitioner had knowledge of search engines and the ability to open and close e-mail, but despite training from Egl, he could not independently attach a document to an e-mail. Petitioner required the assistance of his wife to do that for his job search purposes. (PX 17)

Ragains also noted that while Petitioner received training while in the Air Force between 1975 and 1980 he did have training for operating heavy equipment, he had not undergone any formal vocational training in his civilian life and had no certifications for any particular work functions.

Ragains performed a Transferable Skills Analysis by utilizing his knowledge of the job market, the Dictionary of Occupational Titles and the Vocational Expert Handbook. (PX 17) In performing a Transferability of Skills Analysis, Ragains was attempting to determine whether Petitioner had acquired skills from any of his past relevant employment which he could utilize for residual employment purposes within his job market and in consideration of his age, training and permanent restrictions. (PX 17)

In assessing transferable skills, Ragains stated that he looks only at skills acquired in employment over the previous 15 years as any skills acquired in employment more than 15 years

before had likely atrophied. Ragains considered Petitioner's employment for the Respondent, his employment for the village of Pleasant Hill, his employment installing satellite dishes and his employment as a die-casting operator at Hubble Electric in Louisiana, Missouri. Based on Ragains analysis, it was his opinion that the knowledge acquired from those employment positions would not transfer to other skilled or semi-skilled occupations that would comport to Petitioner's lifting restrictions. Ragains further stated that Petitioner's lifting restrictions did not suggest that he could perform a full range of medium duty work since such work would require good manual dexterity, forceful gripping and grasping, none of which Petitioner possessed due to the impairment of his left upper extremity. (PX 17)

Ragains also noted that the grounds keeping work, material handling, janitorial, and building maintenance jobs are all considered to be semi-skilled jobs at the lowest end of the semi-skilled range and transferability of skills is not generally considered to be present in such low end semi-skilled work.

As a result of his analysis, Ragains did not find that there were any semi-skilled jobs that would be available to Petitioner for employment purposes. Ragains noted that Bose's assessment report "showed no evidence that she conducted a transferable skills analysis, nor did she define a methodology for how she arrived at the "impressions" for how Petitioner might be a candidate for four, non-specific, non-Department of Transportation defined jobs that she recited represented Petitioner's employment potential. Ragains was of the opinion a labor market survey should have been conducted.

Ragains felt Petitioner had conducted a conscientious, diligent and good faith job search and that Petitioner's job search which acted as a labor market survey. In speaking with Petitioner on April 14, 2015 in follow up of his initial meeting Ragains noted that the Petitioner continued to contact from 10 to 15 prospective employers each week within a 50 mile radius of his home. Ragains noted that given Petitioner's qualifications and restrictions, there were not abundant employers within the rural area in which Petitioner resided.

Ragains stated that the fact Petitioner had several interviews suggested to him that he was completing his applications and conducting his job search diligently and in good faith and was further proof that Petitioner was not employable in his surrounding job market. Ragains was of the opinion that a stable labor market did not exist within which Petitioner could find suitable and continuous employment in light of his age, lack of transferable skills and his work restrictions.

(PX 17) Ragains stated that Petitioner's age was also an impediment to future employment since employers are frequently unwilling to hire someone of advanced years due to their limited remaining work life. Ragains also did not believe that Petitioner was a candidate for retraining.

The Arbitrator notes Bose' criticisms of Petitioner's job search. However, the Arbitrator further notes that Respondent chose not to provide vocational rehabilitation services and stated in February of 2015 that MedVoc had provided Petitioner with the tools necessary to complete a job search. Specifically, Ms. Bose testified that as of February 23, 2015, the Petitioner had the skills necessary to find suitable employment. She said that with the help of her company, the Petitioner successfully applied on-line to work as an unarmed security guard. She did not know about the results of said application. She said the he did not need any further services from her business. She said he understood everything he needed to find work, and that he had the skills to obtain the targeted jobs. She did not, however, do a labor market survey which could have potentially provider the Petitioner with more direction as to where to apply for work.

The Arbitrator believes that the issue becomes whether the Petitioner performed a diligent job search after MedVoc discontinued its services. The Arbitrator believes the evidence shows such a search, relying primarily on the opinions of Mr. Ragains. As such, he has met his burden of proving an odd-lot permanent and total.

First of all, Respondent terminated Petitioner's maintenance benefits on February 23, 2015, even though Ms. Bose testified that as of that date he was equipped with the knowledge to find suitable employment. The lack of benefits impeded his ability to search for work as it limited his ability to maintain internet and phone service, as well as being able to buy gas for his vehicle.

Furthermore, as pointed out by Ragains, the fact that Petitioner received job interviews confirms that Petitioner presented himself in his applications for employment, whether online or in person, in a professional and good faith manner. The Arbitrator also notes the labor market in which Petitioner had to look for work is largely rural and many of the larger cities are not within a 50 mile radius of his home.

Respondent did not prove, and Bose did not testify, that Bose had any knowledge of the labor market in which Petitioner was seeking employment. Respondent offered no evidence that any suitable work currently existed in Petitioner's labor market within which Petitioner could locate continuous and gainful employment

Ms. Bose was further critical of the Petitioner's search efforts for several reasons; none of which are persuasive to the Arbitrator. First of all, she was critical with respect to the Petitioner's use of job search forms provided by his attorney, as opposed to those provided by her agency. The Arbitrator has looked at both forms, contained in PX 14, and finds them to be basically identical. Secondly, she said that the Petitioner should have first determined if an employer was hiring before making contact. Perhaps a labor market survey may have him helped in that regard. Despite having no benefits, the Petitioner made essentially the number of job contacts suggested by Ms. Bose at least through mid August of 2015. The job logs and his testimony establish that he left resumes or applications when they were being accepted. While he did not apply online, he had a problem keeping internet service and his closest public internet access was at a McDonald's restaurant twenty miles from his home. As stated above, the Arbitrator agrees with the assessment of Mr. Ragains that a good faith job search has been performed.

Petitioner need not be reduced to a state of total physical incapacity before a permanent and total disability award may be granted. *Westin Hotel v. Indus'l Comm'n 372 Ill.App. 3d 527, 544 (2007)* To prove 'odd-lot' permanent and total disability status, Petitioner 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 labor market. *Id at 544.* The Petitioner satisfies his burden of proof that he falls into the 'odd-lot' category in one of two ways: (1) by showing diligent but unsuccessful attempts to find work, or (2) by showing that because of his age, skills, training, and work history, he will not be regularly employed in a well-known branch of the labor market. *Westin at 544.* Once the Petitioner establishes that he falls into the "odd-lot" category of permanent and total disability, the burden shifts to the Respondent to prove that Petitioner is employable in a stable labor market and that such a market exists. *Westin at 544.*

The Arbitrator notes that Petitioner presented both types of evidence though he was not required to do so. Petitioner presented evidence of a diligent, yet unsuccessful job search. Petitioner also submitted the credible testimony of Certified Vocational Counselor Jim Ragains who was of the opinion that in light of Petitioner's failed job search, his age, lack of transferable skills, physical restrictions, and the labor market in which he lived, Petitioner was not employable. The Petitioner therefore carried his burden of proving that he fell into the "odd-lot' category of permanent and total disability.

The burden of proof therefore shifted to Respondent to demonstrate that that suitable work is continuously available in Petitioner's labor market. The Arbitrator finds that the Respondent failed to satisfy its' burden of proof.

The Arbitrator finds that Petitioner is permanently and totally disabled as he falls into the 'odd-lot' category of permanent and total disability.

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

Adam Stock,
Petitioner,
vs.

NO: 15WC 25699

State of Illinois, CMS,
Respondent,

17IWCC0029

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 16, 2016, is hereby affirmed and adopted.

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

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

DATED: JAN 2 3 2017
MJB/bm
o-1/10/17
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

STOCK, ADAM
Employee/Petitioner

Case# **15WC025699**

STATE OF ILLINOIS CMS
Employer/Respondent

17IWCC0029

On 6/16/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.40% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

5041 ACKERMAN LAW OFFICE
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SPRINGFIELD, IL 62704

0499 CMS RISK MANAGEMENT
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SPRINGFIELD, IL 62794-9208

5260 ASSISTANT ATTORNEY GENERAL
KRISTINA D DION
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0498 STATE OF ILLINOIS
ATTORNEY GENERAL
100 W ERANDOLPH ST 13TH FL
CHICAGO, IL 60601-3227

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

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

JUN 16 2016

Ronald A. Rucci
Assistant Secretary
Illinois Workers' Compensation Commission

STATE OF ILLINOIS)
)SS.
COUNTY OF Sangamon)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Adam Stock
Employee/Petitioner

v.

State of Illinois CMS
Employer/Respondent

Case # **15** WC **025699**

Consolidated cases:

17IWCC0029

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable McCarthy Arbitrator of the Commission, in the city of **Springfield**, on **April 21, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☐ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☐ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☐ 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 26, 3015 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 **$57,148**; the average weekly wage was **$1,099.00.**

On the date of accident, Petitioner was 38 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 **$21,427.42** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$0**.

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

ORDER

Respondent shall pay Petitioner the sum of $659.40/week for a further period of 43 weeks, as provided in Section 8 (e) of the Act, because the injuries sustained caused a 20 % loss of use of the left leg.

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

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

D. Dyas McCarty

6/9/2016

JUN 16 2016

Facts 17IWCC0029

Petitioner hurt his left leg on 05/26/15 when he tripped at work. Later that day he went to Passavant Hospital, where he had an X-ray of the left knee, which showed moderate joint effusion. On 06/02/15 he had an MRI. It showed he had a large effusion, increased T2 signal in subcutaneous fat about the knee, extensive cartilage thinning, and a full thickness cartilage defect measuring 1.3 cm.

He saw Dr Werries on 06/12/15. Dr. Werries took Petitioner off work until further notice and recommended surgery.

On July 23, 2015 Dr. Werries performed surgery on Petitioner's left leg. During the surgery he found Petitioner had chondral lesion with flaps. He debrided about 6 X 6 mm then used a 90-degree awl to perform a micro-fracture. There was fraying of the medial femoral condyle, so he debrided the condyle. He found a loose body in intra-condylar notch, which looked cartilaginous without any attachment, and removed it. It measured 13 mm X 13 mm. Dr. Werries debrided the donor site, which was down to the bone. Dr. Werries felt the loose body would not heal without any bone to which to attach so he did a micro-fracture of this one too.

On 7/31/15 Petitioner saw Dr. Werries who allowed petitioner to do sit down work only.

Petitioner went to physical therapy the following dates, 08/05/15, 08/07/15, 08/10/15, 08/12/15, 08/14/15, 08/17/15, 08/19/15, and 08/21/15.

On 08/21/15 Petitioner saw Dr. Werries, who noted Petitioner still has pain when using it or exercising. Petitioner was off medicine and on crutches.

Petitioner again went to physical therapy on the following dates: 08/24/15, 08/25/15, 08/27/15, 09/01/15, 09/02/15, 09/04/15, 09/09/15, 09/11/15, 09/14/15, 09/16/15.

Petitioner saw Dr. Werries again on 09/18/15. Dr. Werries said Petitioner was doing pretty well and in therapy. Werries limited Petitioner to sitting only.

Petitioner continued physical therapy on 09/22/16, 09/24/15, 09/29/15, 10/01/15, 10/06/15, 10/08/15, and 10/13/15.

Dr. Werries saw Petitioner again on 10/19/15. He noted that Petitioner was doing well, but still has pain. He limited Petitioner to no standing over 1 hour, no climbing, and no squatting.

On 11/20/15 Dr. Werries examined the Petitioner again. Petitioner had excessive pain which was worse than at the last visit which got worse with activing and

stairs. He noted that the brace makes it worse. He found a trace of effusion and quadriceps atrophy.

On November 30, 2015 Dr. Milos did a medical peer review, who found that all meds are reasonable because the surgery was so extensive. (Pet. #3)

On 11/30/15 Dr. Werrries noted the Petitioner had trouble with stairs – going down is especially difficult. On 12/18/15 Dr. Werries found restricted range of motion. He allowed Petitioner to return to work 4 hours per day for two weeks, then full days. Werries, on 01/04/16, said the Petitioner could to return to work full duty. On 01/27/16 Dr. Werries noted that Petitioner was doing better. Petitioner's leg still hurt with a lot of activity. On 02/19/16 Dr. Werries noted an antalgic gait, trace effusion and recommended Petitioner wear a brace while working.

Petitioner worked at the State of Illinois – CMS, as a building grounds laborer. Petitioner did not return to his doctor before trial. He works at the state fairgrounds. He mows about 400 acres. He also strings trims, runs chainsaws, cuts down trees, plants trees, puts dirt in horse stalls, by hand, scoops snow by hand, sprays weeds, cleans buildings, waxes and mops floors. He must work on huge hills. He has worked there for 16 years. He returned to that job after the injury without a pay cut. He has not received a pay increase. While petitioner said he could do his full job, (Tr. 17) he is concerned he will not be able to get another job as a laborer because of his condition. He testified it would be "very difficult" for him to find another laboring job. (Tr. 19) He still does the work, but he has pain when he does the job.

He had wasting of the quadriceps muscle - atrophy. He had 24 sessions of physical therapy but the atrophy did not resolve. He says he still has atrophy (Tr. 9) He says the two legs are "noticeably different;" the left is smaller. The left is significantly weaker than the right. He favors his leg going up the stairs. He can walk about a half a mile. (Tr. 14) His leg makes it difficult for Petitioner to walk on steep his or bad terrain. Stairs are very difficult; he can only do about 25 steps before he gets throbbing pain. Uneven terrain affects him the same way.

Petitioner is unable to play with his daughter because of the problems. She is five years old and likes to play. He cannot get down on the ground to play with her. At the St. Louis Zoo he got stuck on the ground and could not get back up for a while. He is unable to lift her to his shoulders because she weighs too much.

The leg still swells whenever he works or stands on it for long periods. This normally happens two to three times a week. Once it swells it goes down after about an hour. He takes Celebrex most days. The weather affects his leg. Whenever there is a storm or cold weather it gets worse. Before the injury Petitioner worked out and ran. He must now work out to keep his leg in shape, but he cannot run at all. (Tr. 18). He must do exercises at home to keep his leg stable. He does quad flexes, straight leg raises and back curls. (Tr. 9) He does them every night. He does five sets of 10 repetitions of

each of the exercises. He sometimes straps weights to his leg for extra resistance, but he cannot use more than 5 pounds. This normally takes him 20 - 30 minutes per night.

Conclusions of Law

(i) The reported level of impairment pursuant to subsection (a);

There was no impairment rating

(ii) The occupation of the injured employee;

Laborer. The job will require the Petitioner to do physical work involving yard and grounds maintenance. This factor favors the Petitioner's claim.

(iii) The age of the employee at the time of the injury;

Petitioner was 38 years old on his accident date. As he is of a younger age, he will likely have to deal with his disability for a extended period of time at work. This factor favors the Petitioner's claim.

(iv) The employee's future earning capacity;

Petitioner is performing his regular job. There is no evidence of a future wage loss. This factor favors the Respondent.

(v) Evidence of disability corroborated by the treating medical records.

Petitioner had an extensive injury to the left knee involving the patella and both the medial and lateral femoral condyles. (See operative report- PX 2) Following his surgery, he had an extended period of physical therapy and was restricted from full duty work until the end of 2015.

When last seen by Dr. Werries on February 19, 2016, he still had positive objective findings, as indicated in the fact statement, above.

The Petitioner's testimony at arbitration was consistent with the physical findings noted by Dr. Werries.

Based upon an analysis of the above factors, the Petitioner is awarded 20 % of the left leg.

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

PHIL CARELLO,

Petitioner,

vs. NO: 05 WC 27417

NORTHFIELD TOWNSHIP HIGH SCHOOL DISTRICT #225,

17IWCC0030

Respondent.

DECISION AND OPINION ON REMAND

This matter comes before the Commission on remand from the Circuit Court of Cook County. Pursuant to its August 11, 2015 Order, the Honorable Judge Carl Anthony Walker found that there was no affirmative requirement under 820 ILCS 305/8(d)(1) that a claimant conduct a job search to become eligible for an award of benefits thereunder. Therefore, the matter was reversed and remanded back to the Commission with instructions to:

> [M]ake appropriate findings of fact and conclusions of law necessary to determine if Plaintiff is entitled to wage-differential award under 820 ILCS 305/8(d)(1) based on the difference between the average amount Plaintiff would be able to earn in the full performance of his duties in the occupation in which he was engaged at the time of his injury and the average amount he is *able* to earn i[n] some suitable employment after his injury.

The Commission in its Corrected Decision of September 4, 2014, clarified and otherwise affirmed the Arbitrator's Decision of September 4, 2013. In its Decision, the Commission found that Respondent paid $17,014.05 for Petitioner's periods of temporary partial disability (TPD) and temporary total disability (TTD). This amount satisfied TPD and TTD owed Petitioner and

17IWCC0030

could not be used as a credit against any permanent partial disability (PPD) award. The Commission otherwise affirmed and adopted the Arbitrator's Decision which ordered Respondent to pay "Petitioner the sum of $459.79/week for a period of 200 weeks as provided in Section 8(d)2 of the Act because the injuries sustained caused the partial disability of said Petitioner to the extent of 40% thereof."

In addressing the issue of whether Petitioner was entitled to a wage differential award under Section 8(d)1 instead of Section 8(d)2 of the Act, the Arbitrator found that Petitioner did not provide sufficient evidence to support his wage differential claim. The Arbitrator, therefore, awarded Petitioner PPD benefits of 40% loss of man as a whole under Section 8(d)2.

In Pietrzak v. Indus. Comm'n, the Court stated that to qualify for a wage differential award under Section 8(d)1, "claimant must prove (1) partial incapacity that prevents him from pursuing his 'usual and customary line of employment,' and (2) impairment of earnings." 329 Ill. App. 3d 828, 835 (1st Dist. 2002) (citing Gallianetti v. Indus. Comm'n, 315 Ill. App. 3d 721, 730 (3rd Dist. 2000). Our Appellate Court in Gallianetti v. Indus. Comm'n explained that, "There is no affirmative requirement under Section 8(d)(1) that a claimant even conduct a job search. Rather, as discussed above, a claimant need only demonstrate an impairment of earnings. Evidence of a job search is but one way to show impairment of earnings." 315 Ill. App. 3d 721, 731 (3rd Dist. 2000).

While Petitioner and the Circuit Court are correct, in that evidence of a job search is not required under the Act or any case law, Petitioner has the burden of proving both that his injury precludes him from "pursuing his 'usual and customary line of employment'" and an "impairment of earnings."

At arbitration, Petitioner provided a detailed explanation as to his career history in gymnastics that began in 1966. By his testimony, he considered spotting to be the most important duty for a gymnastics coach. Petitioner stated:

> There are different variables in spotting. You have the weight of the gymnast, the height of the gymnast, the speed he's going at, and how far he's falling. You're doing full support. Spotting is breaking their fall on a skill, and you don't know what -- where you're going to have to come in to break their fall. You can't just stand there. If you stand there, it's too late; they're on the ground. (T.19).

Petitioner further testified that you "need full rotation of both arms to adequately spot the gymnast." (T.23).

There was no dispute as to the accident of March 10, 2005 or causal connection as to the injury or treatment provided. Petitioner was spotting a gymnast who was doing a back flip when

the gymnast's heel struck Petitioner's left arm. The impact tore Petitioner's left distal biceps tendon. He underwent a left biceps tendon tenotomy and repair with Dr. Craig Phillips on March 30, 2005. Dr. Phillips also performed a subsequent radial nerve neurolysis and excision of heterotopic bone and capsule in the left elbow joint on January 13, 2006.

At arbitration, Petitioner testified that he could not continue in his usual and customary line of employment. He voluntarily resigned on May 25, 2005, as a gymnastics coach for Respondent, allegedly due to his injury. Petitioner stated, "I knew after the accident that I couldn't adequately keep the gymnasts safe in the gym, spotting them and teaching them." (T.51). Petitioner never requested any accommodation from Respondent, arguing that he needed to have full strength to be able to be a gymnastics coach. (T.52). Steven Rockrohr, Respondent's athletic director who was responsible for hiring coaches, confirmed that Petitioner never inquired whether there was work available within his restrictions. (RX2). Thus, Respondent was never afforded an opportunity to consider a possible accommodation.

Petitioner also provided the deposition testimony of Dr. Michael Vender who performed a Section 12 examination on behalf of Petitioner. Due to the risk of re-injury, Dr. Vender opined that Petitioner be restricted from spotting activities on a permanent basis. He recommended no further restrictions. (PX5; PX6).

Respondent's Section 12 examiner, Dr. Paul Papierski, authored a report and addendum. He took into account the valid Functional Capacity Evaluation (FCE) of August 27, 2007 at Athletico by Brian Bartelli, a physical therapist. The FCE noted that Petitioner's typical work day as a gymnastics coach was three hours, six days per week, from November until May. The summer program consisted of working three hours, three days per week, for two months. (PX4).

The FCE stated that Petitioner "performed this test with satisfactory effort and reliability and was able to exceed his own estimations and the DOT/self-reported job demands, except for overhead lifting." Petitioner was able to lift and complete simulated gymnastics tasks without functionally limiting pain. The physical therapist considered that Petitioner's actual work environment "may exceed the capacity the client was tested." With this in mind, the FCE recommended that Petitioner "return to all aspects of coaching gymnastics except those that require him to be responsible for supporting the weight, breaking the fall, lifting, or carrying of athletes." (PX4).

Dr. Papierski agreed that if Petitioner returned to gymnastics, specifically spotting, he would be more susceptible to a recurrence of a bicep tendon tear. (RX1, pgs. 25-26). However, he suggested that Petitioner return to his work as a gymnastics coach and attempt to "start with more experienced athletes that he might be spotting because those athletes would not require as much spotting, and he would be able to work his way back into that kind of work." (RX1, pg. 15).

Although Petitioner made some showing that his injury made it difficult to continue spotting gymnasts (and arguably his prior profession as a gymnastics coach), Petitioner did not prove that he suffered an impairment of earnings.

The parties stipulated that Petitioner would have earned $15,000.00 per year as a gymnastics coach had he not been injured. (T.54; PX25-26). However, Petitioner never requested any accommodation for his work restrictions and voluntarily resigned as a gymnastics coach. Petitioner testified that not all gymnastic events, such as the pommel horse, required spotting. (T.19). Petitioner also taught different skills, instead of spotting, "by putting the gymnast in the – their body in that position by using your arms to show the position that the gymnast should be in when doing that skill." (T.25). Petitioner made no showing as to whether he was truly precluded from earning the additional $15,000.00 per year given his work restrictions.

Petitioner, at the time of the injury and through the date of arbitration, had been working for Respondent as an instructional assistant in the Special Education Department. (T.58-59). There was no testimony or evidence provided as to the specific job duties required for an instructional assistant, the days and hours that Petitioner worked, or what Petitioner earned or could earn in this position.

While Petitioner is not required to submit evidence of a job search, it is an effective and efficient way to demonstrate an impairment of earnings. As the Arbitrator and the Circuit Court noted, Petitioner provided no evidence whether he could find suitable employment within his restrictions, with Respondent or elsewhere, in gymnastics, coaching another sport, teaching an additional subject, or whether he qualified for a different profession altogether. There was no evidence of vocational rehabilitation or a labor market survey. There was no testimony, documentary evidence, or evidence of any kind, type, or style that would serve as a basis for the entry of an award of benefits under Section 8(d)1 of the Act. Since the record is devoid of such evidence, no such award can be justified.

Having answered the question posed in the Circuit Court's Order, the Commission re-affirms its previous Decision dated September 4, 2014, clarifying and otherwise affirming the Decision of the Arbitrator dated September 4, 2013, which is attached hereto and made a part hereof.

IT IS THEREFORE 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.

17IWCC0030

DATED: JAN 2 3 2017

MJB/pm
D: 1/10/17
052

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

YOUNG PARK,

Petitioner,

vs.

NO: 07 WC 51048

17IWCC0031

NORTHSHORE UNIVERSITY
HEALTH SYSTEM,

Respondent.

DECISION AND OPINION ON REMAND

This matter comes before the Commission on remand from the Circuit Court of Cook County. Pursuant to its June 23, 2015 Order, the Honorable Judge Robert Lopez Cepero noted that the Commission failed to "apply Section 6(c) to the facts before it, its decision is clearly erroneous." Therefore, the matter was reversed and remanded back to the Commission with instructions to "address whether any failure in notice unduly prejudiced Glenbrook hospital, and, if not, to fully address the issues of accident, causal connection, reasonable medical expenses, and all other issues necessary to the full and just disposition of this matter."

The Arbitrator, in her February 5, 2014 Decision, specifically addressed the issue of notice noting that she viewed "the issue of notice as a threshold issue in this case."

In addressing the issue of notice, the Arbitrator noted that Petitioner's left hand treatment dated back to 2001. She filed an Application on November 14, 2007 alleging a repetitive trauma injury on November 22, 2006. The Arbitrator noted that Petitioner testified that she developed trigger finger of her left middle finger on November 22, 2006 after removing a device from an ICU patient. Petitioner testified that she underwent treatment that day at the ER; however, the Arbitrator noted those records were not in evidence. Petitioner later acknowledged that she was unsure of the date on which the triggering took place. She also did not complain of triggering at

hearing. Further, Petitioner also testified that she sought job transfers in 2002 and 2004 due to an arthritic thumb and/or finger condition. The Arbitrator noted that neither of those transfers reflected that the condition was work-related. The Arbitrator further noted that Petitioner did not offer any testimony on the issue of manifestation or notice. Petitioner offered two letters dated March 26, 2008 and November 16, 2009 with both of the authoring physicians referring to hand problems and commenting obliquely on causation, but the Arbitrator noted there was no evidence indicating that Petitioner tendered those letters to Respondent prior to hearing.

In support of her Decision, the Arbitrator cited *White v. IWCC*, 374 Ill.App.3d 907 (4th Dist. 2007) stating that, in a repetitive trauma case, "the employee must allege and prove a single, definable accident. The date of such an accident, from which notice must be given, is the date when the injury 'manifested itself.'" The Court further noted in *White* that "an employer's mere knowledge of some type of injury does not establish statutory notice." The Arbitrator noted that the Application, which was filed almost a year after the alleged manifestation date, appeared to be the first notice to Respondent of any claimed work-related condition. Thus, the Arbitrator found Petitioner failed to establish timely notice to Respondent.

The Commission, in its Decision dated October 15, 2014, affirmed and adopted the Arbitrator's Decision in its entirety.

The Commission is of the opinion that the failure in notice unduly prejudiced the Respondent. However, in conformance with the Circuit Court's Order, the Commission will elaborate on the Arbitrator's well-reasoned analysis as to why Petitioner failed to establish timely notice to Respondent.

The record demonstrates that Petitioner had a lengthy history of prior medical treatment to her left hand. Nowhere in those records had Petitioner ever mentioned that her condition was work-related. Additionally, she gave varying accounts of when she began to experience her symptoms and could not be certain if it was November 22, 2006. Petitioner testified that she underwent treatment at the emergency room on November 22, 2006, but those records were not offered into evidence.

The record is devoid of any evidence of notice prior to the filing of the Application for Adjustment of Claim, which was filed on November 7, 2014, almost one year after the alleged accident. She offered no testimony that she provided any notice whatsoever to her supervisor, or any employee for that matter, prior to the filing of the Application. Additionally, the Commission notes that the Request for Hearing form revealed that Respondent has not made a claim for an 8(j) credit, or any credit whatsoever. The Commission finds that Petitioner's lack of any notice until almost one year later unduly prejudiced the Respondent pursuant to Section 6(c) of the Act.

Had the Commission found that Respondent was not unduly prejudiced by the lack of notice, the Commission would still find that Petitioner failed to prove an accident arising out of and in the course of her employment for the reasons stated above.

Having answered the questions posed in the Circuit Court's Order, the Commission re-affirms its previous Decision dated October 15, 2014 affirming the Decision of the Arbitrator dated February 5, 2014, which is attached hereto and made a part hereof. Accordingly, her claim for compensation is hereby denied.

IT IS THEREFORE 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 23 2017

MJB/tdm
D: 12/19/16
052

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

THOMAS NEE,

Petitioner,

vs. NO: 11 WC 4864

CITY OF CHICAGO,

Respondent.

17IWCC0032

DECISION AND OPINION ON REMAND

This matter comes before the Commission on remand from the Appellate Court of Illinois, First District, Workers' Compensation Division. In its Opinion filed February 27, 2015, the Appellate Court reversed the Circuit Court's Decision confirming the Commission's Decision dated September 13, 2012. The Commission reversed the Decision of the Arbitrator dated December 6, 2011 and found Thomas Nee failed to prove an accident arising out of and in the course of his employment.

The Appellate Court remanded the matter back to the Commission noting that:

> Having been exposed to the risk of traversing a curb to a greater degree than a member of the general public by virtue of his status as a traveling employee at the time of his accident, the injury which the claimant suffered when he tripped over the curb was sustained not only in the course of his employment, it also arose out of his employment with the City.
>
> The foregoing analysis leads us to conclude that the Commission's decision denying the claimant benefits under the Act by reason of

17IWCC0032

his failure to prove that he sustained accidental injuries on July 27, 2009, which arose out of his employment with the City is against the manifest weight of the evidence.

In his Decision dated December 6, 2011, the Arbitrator found that Nee sustained an accident arising out of and in the course of his employment when he tripped over a curb and twisted his ankle while working as an inspector. The Arbitrator found causal connection between his right knee and the July 27, 2009 accident based upon the chain of treatment set forth in the medical records. Specifically, the Arbitrator noted that Nee gave a consistent history of injury and sought medical treatment shortly after the accident where he was diagnosed with a Grade 1 medial collateral ligament strain. Nee was provided with a hinged knee brace and ultimately underwent a series of injections, physical therapy, and was noted to be a candidate for surgery in the future. Petitioner testified that, because of his knee injury, he has issues with stairs, walking long distances and using ladders or squatting. The Arbitrator found Nee was temporarily and totally disabled (TTD) for 14-5/7 weeks and sustained 7.5% loss of use of the right leg.

Following the Appellate Court ruling, the Petitioner filed a Motion to Cite Supplemental Authority relative to the nature and extent of his injury. He asked the Commission to consider increasing the permanency award. Respondent filed a response arguing that the Motion should be denied and that the award is excessive and should be reduced.

Based upon the mandate from the Appellate Court, the Commission re-instates the Arbitrator's Decision dated December 6, 2011 finding Petitioner is entitled to 14-5/7 weeks of TTD benefits and 7.5% loss of use of the right leg. The Commission finds that the award of 7.5% loss of use of the leg is supported by the evidence. Petitioner sustained a ligament strain that required injections and physical therapy. The injury has also impacted his ability to navigate stairs, walk long distances, squat, and use ladders.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 6, 2011 is hereby re-instated.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $1,173.71 per week for a period of 14-5/7 weeks, July 29, 2009 through November 8, 2009, 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 $664.72 per week for a period of 16.125 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused 7.5% loss of use of the right leg.

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

17IWCC0032

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 23 2017

Michael J. Brennan

MJB/tdm
D: 1/10/17
52

Thomas J. Tyrrell

Kevin W. Lamborn

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 down	☐ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Kenneth Novak,

Petitioner,

vs.

NO: 12 WC 13690

17IWCC0033

Tree & Land, Inc.,

Respondent.

DECISION AND OPINION ON REVIEW

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

The Commission modifies the temporary total disability period to from April 3, 2012 through August 1, 2012. The date of accident was April 2, 2012, so temporary total disability began on April 3, 2012. Dr. Lorenz found Petitioner at maximum medical improvement on August 1, 2012. This period is 17-2/7 weeks.

The Commission also modifies the maintenance award. The Arbitrator found Petitioner entitled to maintenance benefits from August 9, 2012 through November 18, 2015, the date of the arbitration hearing. Petitioner's job search logs began on August 6, 2012 and go through October 9, 2015. The Commission finds Petitioner's job search was valid and affirms the Arbitrator's finding that Petitioner was entitled to maintenance, but modifies the Arbitrator's Decision to award maintenance benefits from August 6, 2012 through October 9, 2015, the dates

17IWCC0033

of Petitioner's job search logs. This is a period of 165-5/7 weeks. The Commission affirms all else.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $800.00 per week for a period of 17-2/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $800.00 per week for a period of 165-5/7 weeks, that being the period of maintenance under §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that commencing November 18, 2015, Respondent pay Petitioner the sum of $800.00 per week for life under §8(f) of the Act for the reason that the injuries sustained caused the total permanent disability of Petitioner.

IT IS FURTHER ORDERED BY THE COMMISSION 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 $14,743.41 in TTD benefits and $7,656.59 in maintenance benefits for a total credit of $22,400.00.

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

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

JAN 24 2017

DATED:
MB/maw
o12/15/16
43

Mario Basurto

Stephen J. Mathis

David L. Gore

NOTICE OF ARBITRATOR DECISION

NOVAK, KENNETH
Employee/Petitioner

Case# **12WC013690**

17IWCC0033

TREE & LAND INC
Employer/Respondent

On 3/10/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

1521 FITZ & TALLON LLC
RODNEY C BASHFORD
212 W WASHINGTON ST SUITE 2004
CHICAGO, IL 60606

2837 LAW OFFICE OF JOSEPH MARCINIAK
BRENT W HALBLEIB
TWO N LASALLE ST SUITE 2510
CHICAGO, IL 60606

17IWCC0033

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

Kenneth Novak
Employee/Petitioner

v.

Tree & Land, Inc.
Employer/Respondent

Case # **12** WC **13690**

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 **Edward Lee**, Arbitrator of the Commission, in the city of **New Lenox**, on **November 18, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **April 2, 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 **$62,400.00**; the average weekly wage was **$1,200.00**.

On the date of accident, Petitioner was **62** 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 **$14,743.41** for TTD, **$0.00** for TPD, **$7,656.59** for maintenance, and **$0.00** for other benefits, for a total credit of **$22,400.00.**

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

ORDER

THE ARBITRATOR FINDS THAT THE PETITIONER'S CURRENT CONDITION OF ILL BEING IS CAUSALLY RELATED TO THE APRIL 2, 2012 WORK-RELATED ACCIDENT.

THE ARBITRATOR FINDS THAT THE PETITIONER IS ENTITLED TO TTD FROM APRIL 2, 2012 TO AUGUST 9, 2012 AND MAINTAINENCE BENEFITS AUGUST 10, 2012 THRU NOVEMBER 17, 2015 AT $800.00 PER WEEK AND THAT BEGINNING ON NOVEMBER 18, 2015 AND CONTINUING THEREAFTER, THE PETITIONER IS PERMANENT AND TOTALLY DISABLED AND IS ENTITLED TO $800.00 PER WEEK PURSUANT TO SECTION 8(F).

THE ARBITRATOR FINDS THAT THE RESPONDNET SHALL PAY NO PENALTIES, AS PROVIDED IN SECTION 19(K) OF THE ACT; NO PENALTIES AS PROVIDED IN SECTION 19(L) OF THE ACT; NO ATTORNEY'S FEES, AS PROVIDED IN SECTION 16 OF THE ACT.

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

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

Edward Lee — Signature of Arbitrator

3/10/16 — Date

MAR 10 2016

Kenneth Novak v. Tree and Land, Inc.

12 WC 13690

The Petitioner, KENNETH NOVAK, began working for the Respondent, Tree and Land, Inc., in 1982. The Petitioner held the job position of Operating Engineer, Owner/ Operator and Supervisor for the Respondent. The Petitioner held this position for the Respondent for approximately 29 years, up to and including his last day worked for the Respondent on or about April 2, 2012. The Petitioner testified that the Owner/ Operator and Supervisor position included the responsibilities of running and operating heavy equipment, including bulldozers, tractors, scrapers, bobcats, motor graders in order to excavate, move and grade earth. The Petitioner testified that he drove heavy equipment machines that contained controlled attachments such as blades, buckets, scrapers and swing brooms. He was responsible for directing and engaging workers on the job site as to their daily job duties. The Petitioner was a member of Midwest Operating Engineers Local 150 throughout his employment for the Respondent and still remains an active member to date.

The Petitioner injured his neck and lower back when he was walking backwards setting up construction safety cones on the highway. As he was setting up cones on the jobsite/highway there was a recapped tire laying on the roadside that he did not see and the Petitioner tripped and fell backwards landing on his back and neck. The Petitioner testified that he hit the ground extremely hard and felt immediate pain in his back and his neck. The Petitioner then advised other crew members that were present on the jobsite of his accident and further testified that he then contacted the owner of the Respondent, Ms. Karen Matan of said injury. The Petitioner arrived back to his truck and drove himself for emergency care at Silver Cross Hospital, in New Lenox, Illinois, which was located a few miles down the road from the jobsite.

Silver Cross Hospital noted that the Petitioner presents to the emergency department as a walk-in with complaints of a fall that was sustained at work. The complaints affect the left scapular area, left subscapular area, lumbar area, left low back and left mid back. The emergency department physician diagnosed the Petitioner with myofascial lumbar strain, and acute low back

pain; he was advised to follow-up with his physician for further medical care and treatment. (PX # 4)

The Petitioner was then examined by Dr. Mark Lorenz, M.D. on April 4, 2012. Dr. Lorenz's initial examination noted that the Petitioner comes in stating that he fell while at work; he has a significant acute exacerbation of his low back pain; he also has neck pain with headaches and radiation to his shoulder. Activity restrictions were provided to the Petitioner and it was noted that he shall remain off work, obtain an MRI of the neck and the back and return to clinic after the MRI was completed. (PX # 1)

The Petitioner presented himself to Hinsdale Orthopedics Radiology Center on April 6, 2012 for MRI of the cervical spine and the lumbar spine. The impression of the cervical spine MRI is as follows: 1. Increased minimal central canal and increased moderate bilateral neural foraminal stenosis at C4-5. 2. Stable minimal central canal and increased moderate bilateral neural foraminal stenosis at C5-6. 3. Stable moderate left and stable mild right neural foraminal stenosis at C6-7. 4. Increased mild left neural foraminal stenosis at C3-4. The Impression of the lumbar spine is as follows: 1. Moderate central canal and left foraminal narrowing and mild to moderate right foraminal narrowing at L2-3 due to central and left protrusion of the disc and facet arthropathy. This has become slightly more pronounced than seen previously. 2. Disc bulging at L4-5 complicated by facet arthropathy. Moderate left foraminal narrowing with mild to moderate central canal and right foraminal narrowing. 3. Less severe disc bulging at L3-4 again with facet arthropathy, mild to moderate right foraminal and central canal narrowing and mild left foraminal narrowing. 4. Lateralizing spondylosis and facet arthropathy at L5-S1. (PX # 1)

The Petitioner returned for follow-up visit with Dr. Lorenz on April 12, 2012 regarding his cervical spine and lumbar spine. It was noted that the Petitioner had complaints of cervical pain, bilateral arm numbness and tingling, low back pain and bilateral buttocks pain. The Petitioner was ordered to undergo a course of physical therapy for his neck and lower back; obtain an evaluation for epidurals and facet injections; remain on off duty work status and to follow-up for reevaluation. The Petitioner underwent ATI Physical therapy for his cervical and lumber spine from April 12, 2012 thru April 19, 2012. (PX# 1,6)

On April 26, 2012 the Petitioner presented for follow-up with Dr. Lorenz to discuss MRI findings. Dr. Lorenz diagnosed the Petitioner with a C5-6 disc herniation; C6-7 herniation and C4-5 spondylosis; L3-4 disc herniation with spinal stenosis at L3-4; L2-3 disc herniation with spinal stenosis; L3-4 arthrosis and a L5-S1 small central disc herniation with spinal stenosis. Dr. Lorenz further ordered that the Petitioner undergo a cervical diskogram at C4-5, C5-6 and C6-7; return to clinic after the diskogram and remain off work.

The Petitioner presented to Advanced Pain Centers/ Oak Brook Surgical Center with Dr. Eugene Lipov, M.D. for a cervical diskogram on May 25, 2012. The findings noted C4-C5: Concordant pain in the neck, VAS 10/10; C5-C6: Concordant pain in the neck, VAS 10/10; C6-C7: Concordant pain in the neck, VAS 10/10; Radiologic interpretation of the nucleograms are as follows: Non available due to patients dye allergy. (PX# 1,5)

The Petitioner presented to Dr. Lorenz for follow-up on July 9, 2012 for reevaluation. Dr. Lorenz evaluated the Petitioner and noted that the Petitioner presented with an overall pain rating of eight (8). His MRI and discogram was reviewed, cervical discogram from May 25, 2012 shows concordant pain at C4-5, C5-6, and C6-7. The doctor states that it is not recommended the Petitioner have a surgical fusion for axial neck pain at three levels. Dr. Lorenz further recommended that the Petitioner continue with the pain clinic; continue to be off of work; undergo a functional capacity evaluation and return to clinic after the FCE test. (PX #1)

On July 25, 2012 the Petitioner underwent the recommended functional capacity evaluation at ATI Physical Therapy. The Petitioner's FCE was deemed to be valid in nature setting permanent lifting restrictions at the light physical demand level. It was noted that the Petitioner be limited to the following: Work day, 8 hours; lifting above shoulders bilateral, occasional 10.4lbs., frequent lifting not recommended; desk to chair bilateral. Occasional 19.2lbs, frequent 8.2lbs; chair to floor bilateral, occasional 21.4lbs, frequent 10.4lbs. The FCE further notes "The client is employed as a Operating Engineer/ Construction Supervisor, which is considered a MEDIUM Physical Demand Level Position (occasionally lifting 50 lbs.) according to the U.S. Department of Labor's Dictionary of Occupational Titles (#859.683-010). His capabilities fall below this level." (PX # 6)

The Petitioner presented to Dr. Mark Lorenz on August 1, 2012 for reevaluation and to discuss the functional capacity evaluation. The doctor noted that the Petitioner has multilevel

degenerative disease of the cervical spine. He has non-degenerative disease in the lumbar spine. Dr. Lorenz further notes that at this point in time, this patient is clearly not a surgical candidate and recommends that the Petitioner live within the parameters of the FCE. He has reached MMI; permanent light duty recommended with a maximum lift of twenty-one (21) pounds; permanent light duty; follow-up as needed. (PX# 1)

The Petitioner testified at the time of trial that he advised the Respondent, Ms. Karen Matan of his work status throughout the care that he received for this work related accident. On August 6, 2012 the Petitioner contacted Ms. Matan and advised that he had received permanent light duty restrictions from his treating orthopedic physician and requested that he return to work for the Respondent within said restrictions. Ms. Matan advised the Petitioner that she did not have any light duty work available to accommodate the permanent restrictions.

On August 9, 2012 the Petitioner, by and through his counsel, demanded vocational rehabilitation services pursuant to the purview of Section 7110.10 of Chapter II of the Illinois Administrative Code. At this time, the Petitioner also began to search for work within his permanent restrictions and engaged himself in a self-directed job search. The Petitioner made numerous employer contacts per week in attempts to return to gainful employment within his permanent restrictions.

On August 29, 2012 the Petitioner underwent an initial vocational evaluation with his chosen Section 8(a) treater, Ms. Lisa Helma, CRC, of Vocamotive, Inc. This report was generated on September 19, 2012. It was the opinion of the certified rehabilitation counselor that the Petitioner has lost access to his usual and customary line of occupation of Heavy Equipment Operator and that the situational factors are evident that the Petitioner has lost access to the majority of the labor market available to him, thus concluding that his disability is total. (PX # 3,9)

The Petitioner presented himself for an Independent Medical Evaluation with the Respondent's Section 12 examiner on September 18, 2012. The Petitioner was evaluated by Dr. Jeffrey Coe, M.D., it was noted that multiple medical records and diagnostic tests were reviewed as a part of this evaluation. Based on the physical exanimation and the medical records reviewed, Dr. Coe opined that Mr. Novak has reached maximum medical improvement with regard to the sprain/strain injuries to his upper and lower back reported following the accident

for Tree & Land, Inc., on April 2, 2012; that Mr. Novak has persistent, subjective upper and lower back pain and degenerative disc disease and degenerative arthritis of his cervical and lumbar spine and that Mr. Novak would benefit from work restriction to the "light" physical demand level based on the condition of the degenerative arthritis. (PX # 2)

The Petitioner attended a follow-up evaluation with Dr. Lorenz on October 1, 2012. Dr. Lorenz noted that Patient returned to ask if a TENS unit would be appropriate. He has chronic pain syndrome and multi-level degenerative disease without neurologic deficit. Dr. Lorenz advised the Petitioner that at this point in time he needs to return to his pain management physician, and the pain management physician will likely prescribe the TENS unit for him. He has a permanent restriction of twenty one pounds per his FCE.

The Petitioner attended follow-up visits with his pain management doctor Dr. Gawtham Gutta, M.D. of Clinical Associates in Medicine, L.L.C. from October 9, 2012 though January 29, 2013.

The Petitioner then presented him self back at Dr. Lorenz's office for revaluation on May 9, 2013. Dr. Lorenz noted that Patient returns for re-evaluation and has no change in his previous symptoms or any new symptoms. He continues to have pain 8/10. He has neck pain with arm pain bilaterally and numbness in the hands. His back pain radiates mostly to the left thigh posteriorly but does not go past the knee. He is still seeing Dr. Gutta for pain management. Dr. Lorenz recommended that the Petitioner return to work with a permanent light duty restriction corresponding with no lifting greater than 21lbs. Dr. Lorenz reiterates his opinion that the Petitioner is not a surgical candidate and that he should continue to see Dr. Gutta for pain management and return to clinic per request needed. (PX# 1,7)

IN REGARDS TO (F) "IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY?" THE ARBITRATOR SHALL FIND:

The evidence at the trial of this matter shows that the Petitioner was injured while working in the scope of his employment with Respondent. Prior to the accident, Petitioner had worked for Respondent for more than thirty (30) years as a heavy machine operating engineer. Petitioner had never been placed on any type of restrictive duty during the time he was employed with Respondent. Prior to the work place accident, Petitioner had been diagnosed with degenerative changes in his cervical and lumbar spine. Notwithstanding the preexisting medical condition, Petitioner was able to operate heavy machinery and carry heavy materials such as retaining wall blocks, trees, sleeper ties and grass sod. Petitioner operated Bob Cats, Hay Spreaders, Bulldozers, and Back Hoes, all of which involved a heavy to moderate physical activity on a daily basis and involved Petitioner being thrown around inside the heavy machines on a daily basis.

The Petitioner fell at work, suffered an acute exacerbation of the preexisting degenerative conditions in his cervical spine and lumbar spine, and the exacerbation is permanent, leading to permanent restrictions. Respondent's section 12 examiner, Dr. Jeffrey Coe agrees that Petitioner suffered an aggravation to a preexisting condition in the work place accident that has caused permanent and persistent cervical and lumbar pain and permanent restrictions. This is also confirmed by Petitioner's orthopedic surgeon, Dr. Mark Lorenz.

IN REGARDS TO (K) "WHAT TEMPORARY BENEFITS ARE IN DISPUTE" (MAINTENANCE) THE ARBITRATOR SHALL FIND:

As soon as the Petitioner reached maximum medical improvement (MMI) temporary total disability benefits (TTD) benefits ceased. Petitioner then requested vocational rehabilitation services from the Respondent. Respondent refused to provide and/or approve vocational rehabilitation. Petitioner retained Vocamotive in an attempt to gain vocational rehabilitation and job seeking skills. Lisa Helma, CRC, evaluated Petitioner and due to Petitioner's situational factors and permanent restrictions, found that his disability was total in nature and he would not benefit from vocational rehabilitation. Notwithstanding Ms. Helma's findings, Petitioner has conducted self-directed job searches from August 9, 2012 through the time he testified at trial that were provided to the Respondent on a weekly basis. Petitioner's job search was voluminous and diligent through as set forth in National Tea Co. v. Industrial Commission, *97 Ill. 2d 424b (1983)*. The Arbitrator shall find that the Petitioner is entitled to maintenance in the amount of $800.00 per week from August 9, 2012 through the present date. The Respondent shall be given a credit for any amounts of maintenance benefits paid.

IN REGARDS TO (L) "WHAT IS THE NATURE AND EXTENT OF THE INJURY" THE ARBITRATOR SHALL FIND:

Pursuant to the evidence submitted at trial and the testimony of the Petitioner, his disability is permanent and total in nature. His job prior to the work place accident on April 2, 2012 required effort at a medium physical demand level. Pursuant to the valid FCE, his current capabilities fall far below the medium demand level and his restriction of light physical demand level are permanent. The Illinois Appellate Court provided a legal analysis in Contour Designs, Inc. v. Industrial Commission, 255 Ill. App. 3d 816, 627 NE2d 717 (1994) relevant to the instant case. Citing Ceco Corp v. Industrial Commission, 95 Ill. 2d 278, 286-87 (1983), the Appellate Court stated: "This court has frequently held that an employee is totally and permanently disabled when he is unable to make contribution to the work force sufficient to justify the payment of wages. (Citations) The claimant need not, however, be reduced to total physical incapacity before a permanent total disability award may be granted. (Citations) Rather, a person is totally disabled when he is incapable of performing services except those for which there is no reasonable stable market. (Citation) Conversely, an employee is not entitled to total and permanent disability compensation if he is qualified for and capable of obtaining gainful employment without serious risk to his life. (Citation) In determining a claimant's employment potential, his ag, training, education, and experiences should be taken into account. (Citations)" The Contour Designs Court then went on to state: "Once the employee has initially established that he falls in what has been termed the "odd-lot" category (one who, though not altogether incapacitated for work, is so handicapped that he will not be employed regularly in any well-known branch of the labor market (2 A. Larson, Workman's Compensation, sec. 57.51, at 10-164.24 (1980)), then the burden shifts to the employer to show that some kind of suitable work is regularly and continuously available to the claimant (2. Larson, Workmen's Compensation sec. 57.61, at 10-164.97 (1980))."

Based on the foregoing analysis, the Petitioner in this case falls into the "odd-lot" category for permanent and total disability. The Arbitrator finds that, based on upon all the medical evidence, Petitioner's self-directed job search records and the credible testimony of Ms. Lisa Helma, CRC, and the Petitioner has met his burden of proof that he falls in the "odd-lot" category for permanent and total disability.

The Arbitrator shall find that the Petitioner is entitled to TTD/Maintenance from April 2, 2012 through November 17, 2015 at $800.00 per week and that beginning on November 18, 2015 and

continuing thereafter, the Petitioner is permanent and totally disabled and is entitled to $800.00 per week pursuant to Section 8(f).

IN REGARDS TO PENALTIES PURSUANT TO 19(K), 19(L) AND SECTION 16 OF THE ACT, THE ARBITRATORS FINDS:

The Arbitrator finds that there was a legitimate issue of causal connection upon which Respondent relied. Accordingly, the Arbitrator concludes the Respondent was not vexatious and therefore, does not award penalties or attorney fees.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Robin J. Barnett,

Petitioner,

vs.

NO: 12 WC 33194

17IWCC0034

Illinois Transportation and Refrigeration,

Respondent.

DECISION AND OPINION ON REVIEW

This matter comes before the Commission on Petitioner's Petition for Review of the Order of Arbitrator Carlson denying Petitioner's Motion to Reinstate the case. After due consideration, the Commission denies Petitioner's Petition for Review finding that it was untimely filed and therefore lacks jurisdiction and the Order of Arbitrator Carlson denying reinstatement of the case is final for the reasons set forth below.

1. Petitioner, through his attorney, filed an Application for Adjustment of Claim on September 24, 2012, which alleged a date of accident of June 27, 2007 and that he fell from a machine and sustained injury to his neck and back.

2. On November 10, 2015, Arbitrator Carlson dismissed the claim for want of prosecution. On November 19, 2015, Petitioner's attorney filed a Motion to Reinstate the case. The Motion was set to be heard on January 6, 2016. On January 6, 2016, Arbitrator Carlson granted the Motion to Reinstate the case.

3. The case then came on status call and was set for trial on March 11, 2016. On March 11, 2016, Petitioner's attorney did not appear and the case was dismissed for want of prosecution. On March 22, 2016, Petitioner's attorney filed a Motion to Reinstate the case. There was a

17IWCC0034

hearing on the Motion to Reinstate the case on April 7, 2016 and Petitioner's attorney did not appear. On April 7, 2016, Arbitrator Carlson dismissed Petitioner's Motion to Reinstate the case.

4. On April 11, 2016, Petitioner's attorney filed another Motion to Reinstate the case. In its Motion, Petitioner's attorney referred to the dismissal of November 10, 2015. There was a hearing on the Motion to Reinstate the case on May 9, 2016 and Arbitrator Carlson denied same on that date.

5. Also on May 9, 2016, Petitioner's attorney filed another Motion to Reinstate the case. In its Motion, Petitioner's attorney referred to the dismissal of March 11, 2016. There was a hearing on the Motion to Reinstate the case on June 13, 2016 and Arbitrator Carlson denied same on that date. A record was made.

At the June 13, 2016 hearing, the Arbitrator was informed that Petitioner's attorney did not have his file with him (Tr 4). Respondent's attorney indicated that the Application for Adjustment of Claim was filed on November 24, 2012 (Tr 4). The Commission notes that the Application was actually filed on September 24, 2012. Petitioner's attorney indicated that the date of accident was June 27, 2007 and that Petitioner fell from a machine and injured his neck and back (Tr 4). Petitioner's attorney indicated that Petitioner finished treating within 2 years of the date of the Application filing on September 24, 2012 (Tr 4-5). Petitioner has been finished treating probably since 2014 (Tr 5). Petitioner's attorney knew that Petitioner had major back surgery and knew he had been seeing his doctor periodically. Petitioner never did return to work (Tr 5). Petitioner's attorney believed Petitioner had filed for Social Security Disability (Tr 5). Petitioner's attorney did not believe that Petitioner has undergone vocational rehabilitation (Tr 5-6).

The Arbitrator asked if the claim had ever been dismissed for want of prosecution before (Tr 6). Petitioner's attorney replied, "Counsel, in our discussion before the hearing today, had stated that it was. I have not seen a DWP order. I know that we previously did file a Petition to Reinstate, but I can't speak to that for sure." (Tr 6). The Arbitrator asked when was the first date of dismissal (Tr 6). Petitioner's attorney asked Respondent's attorney if he had that information (Tr 6). Respondent's attorney indicated that the case was dismissed on November 10, 2015 and Petitioner's attorney filed a Petition to Reinstate the case on November 19, 2015 (Tr 6). Respondent's attorney did not have an order showing reinstatement of the case (Tr 6). The Commission notes that the case was reinstated on January 6, 2016 by Arbitrator Carlson. Respondent's attorney indicated that the case did come up on the trial list on March 11, 2016 and no one appeared on behalf of Petitioner for the trial date (Tr 6). Respondent's attorney indicated the case was dismissed for want of prosecution on March 11, 2016 (Tr 6). A Motion to Reinstate the case was filed on March 22, 2016 (Tr 6).

The first dismissal for want of prosecution was on November 10, 2015, Petition to Reinstate was filed November 19, 2015, then the case was reinstated on January 6, 2016. The second dismissal for want of prosecution was on March 11, 2016 (Tr 7). Petitioner's attorney then stated, "Judge, I will say though the November 10, 2015 date, I believe the only basis for counsel saying it was DWP'd on that date is because we filed a Petition to Reinstate. I have not seen anything or we never received a notice stating it was DWP'd." (Tr 7). The Arbitrator replied, "That doesn't make any sense to me because, if it was dismissed on 11-10-2015 and a reinstatement motion was filed only nine days later, that's not enough time for the Commission to process a reinstatement. Nine days isn't enough." (Tr 7). Respondent's attorney indicated that 9 days later was when the Motion to Reinstate was filed (Tr 7). The Arbitrator stated, "Right; but even so, the Commission can't process a DWP that quickly." (Tr 7). Respondent's attorney agreed (Tr 7). The Arbitrator stated, "So it would seem to me that the parties were aware of the dismissal on the date that it was dismissed or very shortly thereafter." (Tr 8). Petitioner's attorney stated, "Judge, but what's also possible is that we knew that we missed an above-the-line date and, knowing that and having not received a notice, we assumed it was DWP'd; so we filed a Petition to Reinstate." (Tr 8). The Arbitrator stated, "I imagine that's possible, yes." (Tr 8). Petitioner's attorney stated, "That's my mode of operation. If I miss a trial date and I realize it was above the line, I file the petition right away just to be safe." (Tr 8).

The Arbitrator asked if accident was being disputed on this claim (Tr 8). Respondent's attorney replied that there is a Statute of Limitations defense on it and also issues of accident and causal connection (Tr 8). Petitioner's attorney indicated that there were payments for medical bills within 2 years before the September 24, 2012 Application filing (Tr 8-9). Respondent's attorney contended that there were not any payments made by Respondent for medical within 2 years preceding the September 24, 2012 date of Application filing and there are disputes over whether the accident occurred and what occurred (Tr 9).

A recess was taken. The Arbitrator returned and indicated he found his call sheet for November 10, 2015 and that it showed Respondent's attorney was there, that the case was above the line and that Petitioner was a no-show at the Commission that day (Tr 9). The Arbitrator indicated that Petitioner's attorney must have gotten some sort of indication that the case was dismissed for want of prosecution. The Arbitrator asked Petitioner's attorney if he had an Order of Reinstatement (Tr 9). Petitioner's attorney stated he did not bring his file and apologized (Tr 10). Respondent's attorney indicated that a Motion to Reinstate was filed on November 19, 2015 and it was motioned up for January 6, 2016 (Tr 10). The Arbitrator asked Petitioner's attorney to retrieve the Commission file from the vault and this was done (Tr 11). Petitioner's attorney retrieved the reinstatement order dated January 6, 2016 (Tr 11). The Arbitrator indicated that it appeared that the case was reinstated on January 6, 2016 (Tr 12). The Arbitrator reiterated that the date of accident was in 2007 and the Application was filed in 2012, which is 5 years after the date of the occurrence (Tr 12). The Arbitrator showed Respondent's attorney the reinstatement order (Tr 12). The Arbitrator indicated that the original dismissal (November 10, 2015) was not in the Commission file (Tr 12).

The Arbitrator indicated that March 11, 2016 was a trial date and asked what happened on that date (Tr 12). Petitioner's attorney stated, "On that date is – and this I can speak from personal knowledge of because I was involved with it – we received an email of the trial date being set off the call date from our clerk service. Miss Poznanki, who was the handling attorney, was not included on that email; so that never ended up on our calendar. We did not appear on March 11, 2016 for that reason; and I believe --." (Tr 12-13). Petitioner's attorney was saying there was a clerking error on that date (Tr 13). The Arbitrator asked if the case was dismissed for want of prosecution a second time and Petitioner's attorney agreed (Tr 13). Petitioner's attorney indicated that a petition was then filed (Tr 13). Respondent's attorney indicated that a Petition to Reinstate the case was filed on March 22, 2016 and heard on April 7, 2016 and denied on that date because no one from Petitioner's attorney's firm appeared that day (Tr 13). Petitioner's attorney then stated he was mixing up the March 11, 2016 trial date and the April 7, 2016 hearing date (Tr 13-14). Petitioner's attorney stated, "The April 7th date, after we filed the motion, that date did not end up on our calendar. March 11, I don't know why we weren't here." (Tr 14). "THE ARBITRATOR: So there's no show on 3-11 and a no show on 4-7? MR. NEWMAN (Respondent's attorney): Right; and your Honor, April 7th you denied the Petitioner reinstate the case because no one appeared on behalf of Petitioner. We did appear on behalf of Respondent and asked you not to reinstate the case in the circumstance that no one appeared on behalf of Petitioner. THE ARBITRATOR: Is that so? MR. BHOSALE (Pestitioner's attorney): You know, I'm some confused on the dates because, on the order that we gave you, I know that's the date we were there. I'm not sure which date that was." (Tr 14).

The Arbitrator stated that he had another reinstatement denied on May 9, 2016 (Tr 14). The Commission notes that this was the date of hearing for the April 11, 2016 filing by Petitioner of a Motion to Reinstate the case. Petitioner's attorney believed that between April 7, 2016 and May 9, 2016 there was a Motion to Reinstate filed. The Commission notes that Petitioner filed a Motion to Reinstate on April 11, 2016. Respondent's attorney showed the Arbitrator a copy of the Motion filed on April 11, 2016, which asked to reinstate the case by reversing the dismissal of November 10, 2015, which the Arbitrator stated was confusing (Tr 15-16). The Arbitrator stated that the confusing part is that the Motion itself does not correctly give an accurate chronology of what occurred in the claim. Respondent's attorney agreed and then this Motion to Reinstate that was filed on April 11, 2016 was denied on May 9, 2016 (Tr 16).

The Arbitrator indicated that he did not think that he had jurisdiction to rule on the Motion to Reinstate filed on May 9, 2016 that was before him (Tr 19). The Arbitrator noted that Petitioner's attorney insisted on going on the record and getting another order from him. The Arbitrator denied Petitioner's Motion to Reinstate and both parties were put on immediate notice of the ruling (Tr 19). The Arbitrator added that he agreed with Respondent's position about this and to proceed on this case at this point in time 8 years after the occurrence is highly prejudicial to Respondent (Tr 19). The Arbitrator stated that the only reservation he had was that Petitioner was seriously injured, but did not think the case had been moved through the system in a diligent fashion (Tr 20). Petitioner's attorney indicated that his firm was not retained in 2007 and the case was filed shortly after they were retained in 2012 (Tr 20).

6. On June 17, 2016, Petitioner's attorney filed a Petition for Review on the issue of Whether Petitioner's Motion to Reinstate was properly denied. Both parties filed briefs.

The Commission denies Petitioner's Petition for Review finding that it was untimely filed and therefore lacks jurisdiction and the Order of Arbitrator Carlson denying reinstatement of the case is final. The Commission does not have jurisdiction because the Petition for Review was not timely filed. The case was dismissed on November 10, 2015 for want of prosecution and was reinstated on January 6, 2016. The case was then set for trial on March 11, 2016. On March 11, 2016, Petitioner's attorney did not appear and the case was dismissed for want of prosecution. Petitioner's attorney claimed this was a clerking/docketing error. On March 22, 2016, Petitioner's attorney filed a Motion to Reinstate the case. There was a hearing on the Motion to Reinstate the case on April 7, 2016 and Petitioner's attorney did not appear. Petitioner's attorney claimed this also was a clerking/docketing error. On April 7, 2016, Arbitrator Carlson dismissed Petitioner's Motion to Reinstate the case. Instead of filing a Petition for Review of Arbitrator Carlson's April 7, 2016 Order dismissing the Motion to Reinstate, Petitioner's attorney filed another Motion to Reinstate on April 11, 2016, which was denied on May 9, 2016. Petitioner's attorney filed another Motion to Reinstate on May 9, 2016, which was denied on June 13, 2016. Petitioner's attorney filed a Petition for Review on June 17, 2016. Petitioner's attorney had 30 days after the receipt of the April 7, 2016 Order to file a Petition for Review and did not do so. The Commission finds that Petitioner's Petition for Review was untimely filed and therefore, the Commission lacks jurisdiction. Arbitrator Carlson's April 7, 2016 Order denying reinstatement of the case is therefore final and the Commission affirms same.

The Commission finds that if it had jurisdiction (Petition for Review timely filed after the June 13, 2016 Order), the issue is whether Petitioner's Motion to Reinstate was properly denied by the Arbitrator. The Commission finds that the dismissal for want of prosecution on April 7, 2016 was proper as Petitioner's attorney did not appear for the hearing on his Motion. The Commission also finds that the Arbitrator's subsequent denials on May 9, 2016 and June 13, 2016 were proper as well.

17IWCC0034

IT IS THEREFORE ORDERED BY THE COMMISSION that the April 7, 2016 Order of Arbitrator Carlson denying reinstatement of the case is hereby final and affirmed.

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

DATED: JAN 24 2017
MB/maw
o12/15/16
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 corrections	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

John Johnson,

Petitioner,

vs.

NO: 13 WC 9875

City of Chicago,

17IWCC0035

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Petitioner and Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connection, extent of temporary total disability, nature and extent of permanent disability, date of maximum medical improvement, §8(d)1 benefits v. §8(f) benefits in lieu of §8(d) 2 and §8(e) awards, overpayment of maintenance, improper wage differential and permanent partial disability awards and being advised of the facts and law, corrects the clerical errors in the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission notes that in the credit section on the face sheet, the Arbitrator stated that Respondent overpaid maintenance benefits from September 31, 2014. This should be from October 1, 2013 and the Commission corrects this clerical error. The Commission further finds that it is more appropriate in this case to award permanency under §8(d) 2 than §8(e). The Commission corrects this clerical error by awarding the same total of weeks that was awarded by the Arbitrator, 178.75, under §8(d) 2, which calculates to 35.75% person as a whole. The Commission otherwise affirms and adopts the Decision of the Arbitrator.

17IWCC0035

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 23, 2016 is hereby affirmed and adopted with the above noted corrections of clerical errors.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $1,106.49 per week for a period of 63-5/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $712.55 per week for a period of 178.75 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 35.75%.

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 paid $107,329.53 in TTD benefits, $46,685.41 in overpaid maintenance benefits and $8,537.65 in PPD advance, for a total credit of $162,552.59.

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

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

JAN 24 2017

DATED:
MB/maw
o12/22/16
43

Mario Basurto

Stephen J. Mathis

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

JOHNSON, JOHN
Employee/Petitioner

Case# 13WC009875

17IWCC0035

CITY OF CHICAGO
Employer/Respondent

On 5/23/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.37% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4128 RUBENS AND KRESS
FRANK D KRESS
134 N LASALLE ST SUITE 444
CHICAGO, IL 60602

0010 CITY OF CHICAGO
STEPHANIE LIPMAN
30 N LASALLE ST SUITE 800
CHICAGO, IL 60602

17IWCC0035

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

John Johnson
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # 13 WC 9875

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 **December 2, 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] What temporary benefits are in dispute?
   [ ] TPD [x] Maintenance [x] TTD
L. [x] What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [x] Is Respondent due any credit?
O. [x] Other **On what date did the Petitioner reach Maximum Medical Improvement?**

17IWCC0035

FINDINGS

On **July 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 $ **86,306.21**; the average weekly wage was $**1,659.73**.

On the date of accident, Petitioner was **54** 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 $ **107,329.53** for TTD. Respondent shall be given a credit for overpaid maintenance benefits from 09-31-14 to 08-03-15 (44 weeks) or **$ 46,685.41** and Respondent shall be given a credit for **$ 8,537.65** (advance against permanency) for a total credit of $ **162,552.59**.

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

ORDER

Maximum Medical Improvement

The Petitioner reached maximum medical improvement on September 30, 2013 (left leg). No temporary total disability or maintenance benefits are awarded after this date.

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $1,106.49/week for 63.714 weeks, commencing 07-11-12 through 09-30-13, as provided in Section 8(b) of the Act.

Maintenance

Respondent is entitled to a credit for overpaid t.t.d. or maintenance benefits from 09-31-14 to 08-03-15.

Section 8(d)1 Benefits

Petitioner is <u>not</u> totally and permanently disabled.

Section 8(d)(1)

Petitioner is <u>not</u> entitled to a wage differential award under Section 8(d)(1).

Permanent Partial Disability: Person as a whole

Respondent shall pay Petitioner partial disability benefits of $ 712.55 (max) for 125 weeks, because the injuries sustained caused 25% loss of a person as a whole (job loss), as provided in Section 8(d)2 of the Act and an additional 53.75 weeks because the injuries sustained caused 25% loss of use of the left leg. The total award is 178.75 weeks or $127,368.31.

Causal Connection
No causal connection is found for the Petitioner's lumbar spine, cervical spine and shoulder(s) condition(s). However, causal connection is found for Petitioner left leg 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.

Arbitrator Kurt A. Carlson

05-23-16
Date

MAY 23 2016

17IWCC0035

John Johnson v. City of Chicago
13 WC 9875

MEMORANDUM OF DECISION OF THE ARBITRATOR

Findings of Fact

The Petitioner in this matter worked as a blacksmith for the Respondent. The Petitioner explained that his job duties required him to fabricate pieces of metal in order to repair city property. Specifically, the Petitioner provided the example of fashioning pieces of metal together in order to rehabilitate city refuse trucks that had fallen into disrepair. In order to perform the tasks of his job, the Petitioner explained that he had to be able to lift heavy sheets of metal while welding, cutting and placing them in position to make his repairs. The Petitioner testified that the items that he would repair often weighed over one-hundred pounds.

The Petitioner's above testimony describing his work duties was contradicted by his medical records, which show that on November 14, 2006, the Petitioner had permanent sedentary work restrictions. (RX #2) He was instructed to frequently sit and only occasionally walk, stand, climb a ladder, stoop, kneel, squat, crouch or crawl. These permanent restrictions were caused by a low back injury at work in 2005, where he was off work for 535 days. Petitioner was offered surgery in 2006, but declined. He had a previous low back injury (HNP) in 2000 where he was off for a year and a similar injury in 1993. (RX #2) Despite the above, Respondent was ostensibly able to accommodate the sedentary restrictions.

On July 11, 2012, the Petitioner was in the process of repairing a refuse truck when his pant leg caught on fire. In an effort to extinguish the flames, the Petitioner tripped over a raised bolt that was on the floor of the truck. The Petitioner testified that when he tripped over the bolt, he twisted his left knee and fell to the floor of the truck.

On July 12, 2012, the Petitioner reported to Advanced Occupational Medicine, the clinic that was suggested to him by the Respondent (Pet. Ex. 1, p. 20-24). The notes from that date indicate that the Petitioner had sustained a left knee sprain.

On July 19, 2012, the Petitioner underwent the MRI of his left knee at Athletic Imaging (Pet. Ex. 1, P. 9-10). The MRI revealed a complex tear involving the posterior medial meniscus that appeared to involve the posterior medial meniscal root with extension to the body horn junction. Based upon the findings of the MRI, the Petitioner was referred to see Dr. Gregory Primus for a surgical consultation (Pet. Ex. 1, P. 13).

On August 17, 2012, Dr. Primus evaluated the Petitioner and recommended surgical intervention to repair the Petitioner's left knee (Pet. Ex. 1, P. 58). Petitioner decided to choose neither Advanced Occupational Medicine nor Dr. Primus, instead seeking Dr. Brian Cole of Midwest Orthopedics who also recommended knee surgery (Pet. Ex. 2, P. 146-147). No low back complaints were recorded. Id.

On November 14, 2012, Dr. Cole performed arthroscopic surgery on the Petitioner's left leg (Pet. Ex. 2, P. 152-154). The operative report revealed a left medial meniscectomy and a three-compartment synovectomy.

On November 26, 2012, the Petitioner retuned to see Dr. Cole for a follow-up examination (Pet. Ex. 2, P. 141-143). Dr. Cole recommended that the Petitioner begin physical therapy at that time. On November 28, 2012, the Petitioner began a regimen of physical therapy at Sports and Ortho (Pet. Ex. 3).

On December 27, 2012, Dr. Cole again evaluated the Petitioner. On that date, Dr. Cole noted that the Petitioner had taken a tumble two weeks prior and noted that the Petitioner had a known herniated disc that had laid him up a bit (Pet. Ex 2, P. 138). Dr. Cole encouraged the Petitioner to stay in physical therapy and continue taking pain medications, ice and elevate his knee and employ a knee brace as necessary. Id. Dr. Cole noted that the Petitioner was attempting to get his back issue under control as well. Id.

The Arbitrator notes that the above record is the first documentation of low back complaints by the Petitioner to his physician. Those complaints do not relate back to the work accident on July 11, 2012, which occurred five months earlier. Instead, they relate to the Petitioner's pre-accident condition or "a tumble" that occurred two week prior.

On February 4, 2013, the Petitioner was again evaluated by Dr. Cole who noted that despite the setback noted in the evaluation of December 27, 2012, Petitioner had improved in physical therapy. (Pet. Ex. 2). Dr. Cole noted that the Petitioner had residual lower back pain for which he had a known history of a herniated disk. Id. Dr. Cole prescribed additional physical therapy. Id. Again, the Arbitrator notes that the low back complaints were not in reference to the work accident on July 12, 2012.

On March 25, 2013, Dr. Cole again examined the Petitioner (Pet. Ex. 2, p. 127). Dr. Cole wrote that he had a thorough discussion with the Petitioner regarding the non-operative management of symptomatic osteoarthritis in the knee. Id. Dr. Cole noted that his work accident caused "an aggravation of a preexisting condition that got [the Petitioner] outside of his symptomatic window and into a need for treatment. Id. Dr. Cole noted ongoing back symptoms as well and recommended that the Petitioner treat both pain generators with a Medrol Dosepak. Id. Dr. Cole recommended that the Petitioner continue with physical therapy Id.

On April 15, 2013, the Petitioner was examined by Dr. Kern Singh, also of Midwest Orthopedics at Rush, due to ongoing complaints of low back pain (Pet. Ex. 2, p. 77-82). Dr. Singh wrote that as a result of the work accident, the Petitioner had had increased axial low back pain and had a left knee injury in which he underwent a meniscal repair by Dr. Cole. (Pet. Ex. 2, P. 79). Dr. Singh noted that the Petitioner had symptoms including sharp, burning, cramping sensations in his low back with symptoms radiating to the posterior and medial aspects of his right lower extremity. Id. Dr. Singh noted that the Petitioner had stated that he had had previous back injuries many years ago and noted that he had had a history of bulging disks. Id. Dr. Singh noted that the

Petitioner's symptoms were getting worse, causing moderate discomfort. Id. Dr. Singh specifically noted that the Petitioner's pain was the result of an on-the-job injury. Id.

The April 15, 2013 medical record with Dr. Kern Singh is the first time the Petitioner related the work accident to his increased low back pain. A time span of nine months had elapsed. Further, the Petitioner told Dr. Singh that "he has had a history of bulging discs. However, he is unsure of the exact details. He denies any history of lumbar spine injury." He informed the doctor that his job is heavy duty. (Pet. Ex. 2 p.79-80)

Dr. Singh recommended that the Petitioner engage in physical therapy to treat his condition and further recommended that the Petitioner call his office to get an order for an MRI if his condition did not improve. (Pet. Ex. 2, P. 81).

On May 7, 2013, the Petitioner did, in fact, undergo an MRI of his lumbar spine. The MRI, performed at Chicago Ridge Radiology, revealed mild bilateral foraminal stenosis due to mild broad-based predominantly central disc bulge at L4-L5 (Pet. Ex. 2. P. 248). Additionally, the MRI revealed mild foraminal stenosis due to a broad-based disc bulge at the L5-S1 level and minimal bilateral foraminal stenosis due to a broad-based disc bulge at the L3-L4 level (Pet. Ex. 2, P. 249).

On May 15, 2013, the Petitioner returned to see Dr. Singh following the MRI (Pet. Ex. 75-76). Dr. Singh diagnosed the Petitioner with a herniated nucleus pulposus at L4-L5 (Pet. Ex. 76). Dr. Singh recommended that the Petitioner see Dr. David Cheng for an epidural steroid injection. Id.

On May 20, 2013, the Petitioner again saw Dr. Cole for his knee (Pet. Ex. 2, P. 72). On this occasion, Dr. Cole noted that given the severity of ongoing knee symptoms, a cortisone injection was indicated. Id.

On June 18, 2013, the Petitioner authored a new patient questionnaire for Dr. David Cheng where he stated that the pain in his back, neck, shoulder and knee were related to the work accident on July 12, 2012. (Pet Ex. 2 p. 191) The Arbitrator notes that there is no history heretofore of a neck or shoulder injury associated with the work accident.

On June 21, 2013, Dr. Cheng performed the injection on the Petitioner's lumbar spine that Dr. Singh had recommended (Pet. Ex. 2, p.59).

On July 1, 2013, the Petitioner saw Dr. Cole again with regard to his knee (Pet. Ex. 2, p.58). Dr. Cole noted that the Petitioner was six weeks post-corticosteroid injection for his knee. Id. Dr. Cole noted improvement with the injection and opined that the Petitioner could have additional injections every three months. Id.

One week after his appointment with Dr. Cole, the Petitioner was examined by Dr. Singh on July 8, 2013 (Pet. Ex. 2, P. 55-56). Dr. Singh recommended that the Petitioner complete two to four weeks of work conditioning and that he follow up with

Dr. Cole with regard to his knee.

On September 30, 2013, Dr. Cole examined the Petitioner a final time. On that date, Dr. Cole placed the Petitioner at maximum medical improvement (Pet. Ex. 2, p.52). Dr. Cole recommended that the Petitioner be limited to seated sedentary work as a result of his work injury. Id. These restrictions match the Petitioner's pre-injury state of physical health. (Resp. Ex. 2 p.1)

Despite having been released with regard to his knee, the Petitioner continued to treat with Dr. Singh for his lumbar spine. On October 28, 2013, Dr. Singh consulted the Petitioner regarding his treatment options and it was decided that the Petitioner would pursue surgical intervention to treat his symptoms (Pet. Ex. 2, p.49). On December 3, 2013, the Dr. Singh performed a minimally invasive L4 and L5 laminectomy with bilateral facetectomy and foraminotomy and a right-sided L4-5 microscopic discectomy (Pet. Ex. 2, p.149-151).

On December 30, 2013, the Petitioner returned to see Dr. Singh (Pet. Ex. 2, p. 45-46). Dr. Singh noted that the Petitioner had improved since the surgery and that his right lower extremity pain had resolved (Pet. Ex. 2, p.45). Dr. Singh recommended that the Petitioner begin physical therapy at that time. Based upon this recommendation, the Petitioner resumed a regimen of physical therapy at Sports and Ortho on January 7, 2014 (Pet. Ex. 3).

On February 10, 2014, the Petitioner performed a functional capacity evaluation at Sports and Ortho at Dr. Singh's prescription (Pet. Ex. 3, P. 195-199).

Dr. Singh noted that the functional capacity examination placed the Petitioner at the medium demand level which would mean that additional work conditioning would be required to get the Petitioner back to work as a blacksmith. However, is does not appear that Dr. Singh was aware of the Petitioner's pre-injury physical capabilities as this FCE placed the Petitioner at a higher work ability level than his pre-injury state. (Resp. Ex. 2 p.1) Nevertheless, based upon the "increase" in the Petitioner's symptoms, Dr. Singh recommended a new MRI (Pet. Ex. 2, p.35).

On March 13, 2014, the Petitioner underwent an MRI of his lumbar spine at Chicago Ridge Radiology (Pet. Ex. 3, p.218). Following the MRI, the Petitioner returned to see Dr. Singh to review the results. Dr. Singh read the MRI to reveal a central disk protrusion at L4-5, as well as a right lateral recess narrowing at L4-5 with a right-sided laminectomy defect as well as diffuse spondylosis (Pet. Ex. 2, p.32). Dr. Singh advised the Petitioner to come back to see him in two weeks in order to determine whether he is a candidate for additional work conditioning versus an L4-5 revision laminectomy with fusion (Pet. Ex. 2, p.32).

On April 7, 2014, Petitioner had opted against pursuing further surgical intervention at that time (Pet. Ex. 2, P. 27). Accordingly, Dr. Singh recommended work conditioning.

On May 21, 2014, the Dr. Singh again evaluated the Petitioner. On that date, Dr. Singh noted that the Petitioner had only attended one additional session of work conditioning due to his pain levels (Pet. Ex. 2, p.23). Dr. Singh noted that he had a long conversation with the Petitioner regarding treatment options and that the Petitioner had decided against any further surgery. Id. Accordingly, Dr. Singh placed the Petitioner at maximum medical improvement and imposed permanent restrictions upon him based upon the results of the February 10, 2014 functional capacity evaluation which stated the Petitioner could return to work at the medium demand level. (Pet. Ex. 2, p.24).

Petitioner's permanent work restrictions are currently greater now than his pre-injury state of physical health. Nevertheless, Respondent failed to accommodate the new restrictions. As a result, the Petitioner began vocational rehabilitation at Vocamotive, beginning with an initial assessment on June 19, 2014. The Petitioner failed to cooperate in job search activities from November of 2014 to August 3, 2015. Petitioner is currently neither seeking additional medical treatment, nor is he employed.

Conclusions of Law

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

The Respondent has disputed whether the Petitioner's current state of ill-being is causally related to his work accident of July 11, 2012. Based upon the entire record, the Arbitrator finds that the left knee condition is compensable. No other portion of this claim is compensable under the Act. Petitioner's lumbar spine condition is not related to the accident on July 11, 2012. Likewise, the Petitioner's neck and shoulder complaints are unrelated to the work accident.

Causal Connection (left knee)

The Petitioner's testimony at trial was that on July 11, 2012, he was in the process of repairing a refuse truck when his pant leg caught on fire. In an effort to extinguish the flames, the Petitioner tripped over a raised bolt that was on the floor of the truck. When he tripped and fell, he twisted his left knee and fell to the floor of the truck. Petitioner sought medical care the next day and gave a consistent accident history to his treaters for his occurrence. The overwhelming majority of records support the Petitioner's contention that the occurrence aggravated the Petitioner's pre-existing left knee condition. As a result, the Arbitrator finds causal connection for the left leg.

Causal Connection (lumbar spine)

Petitioner's lumbar spine is not causally related to the accident on July 11, 2012. While it is true, Dr. Kern Singh gave a causal connection statement relating the Petitioner's low back condition to the work accident and Respondent failed to counter by

requiring cross-examination or a Section 12 opinion of its own; the Arbitrator finds Dr. Singh's opinion to be unpersuasive as it was based upon a false history of back complaints immediately after the occurrence. There simply is no such history in the record. The first attempt by the Petitioner to link his low back pain to the accident on July 11, 2016 did not occur under nearly nine months after he began seeking medical treatment. Further, Dr. Singh's opinion is based upon an unclear history of the Petitioner's previous lumbar spine condition. It appears certain that Dr. Singh was unware of the nature and extent of the Petitioner's pre-injury condition or that Petitioner already had sedentary work restrictions. As a result of the above, causal connection for the lumbar spine is denied.

Causal Connection (cervical spine and shoulders)

The Petitioner also attempted to link unrelated neck and shoulder pain to the accident as well. Again, these claims were far too remote in time and place to be causally connected to accident on July 11, 2012. (Pet. Ex. #2 p. 191) The Arbitrator finds no causal connection for the Petitioner's cervical spine and shoulder claim to the work accident.

(K) What temporary benefits are in dispute?

The parties have a dispute with regard to the payment of maintenance benefits in this matter. The Respondent contends that due to a lack of a diligent effort with regard to vocational rehabilitation, it should not have paid any maintenance benefits subsequent to the date that the Petitioner reached maximum medical improvement.

First, with regard to the date of maximum medical improvement, the Arbitrator finds that the Petitioner's left knee condition stabilized on September 30, 2013, when he was released by Dr. Cole. A full discussion of that issue is addressed in Paragraph (O) of this Decision.

Second, it is clear to the Arbitrator that the Petitioner was uncommitted to seeking work during the time that he was working with Vocamotive and while he was engaged in a self-direct search for work. Vocational rehabilitation was discontinued by the provider due to non-compliance. (Pet. Ex. 4 p.231)

Accordingly, Respondent's request for a reimbursement of maintenance is granted. Petitioner was entitled to temporary total disability and/or maintenance benefits from July 11, 2012 until the date of maximum medical improvement for his left leg on September 30, 2013.

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

Is Petitioner permanently and totally disabled?

The Petitioner in this matter claims to be permanently and totally disabled from the workforce as a result of his injuries of July 11, 2012. "For the purposes of Section 8(f), a person is totally disabled when he cannot perform any services except those for which no reasonably stable market exists. Conversely, if an employee is qualified for and capable of obtaining gainful employment without seriously endangering health or life, such employee is not totally and permanently disabled. In arriving at its determination, the Commission must consider the employee's age, experience, training and capabilities." E.R. Moore Co. v. Indus. Comm'n, 71 Ill.2d 353, 361 (1978) and 820 ILCS 305/8(f). In the present case, Dr. Cole prescribed permanent sedentary restrictions upon the Petitioner with regard to his knee injury, but those restrictions match his pre-injury state. It appears from the record that Dr. Cole was unaware of the Petitioner's pre-injury condition, which was essentially the same those on September 30, 2013 (the date of MMI). Petitioner was able to work as a blacksmith from 2006 until 2012 with permanent sedentary restrictions.

Later, Dr. Singh's prescribed an FCE that placed permanent restrictions on the Petitioner that allowed the Petitioner to exceed the physical demands of the 2006 sedentary restrictions, which pre-date the occurrence. Despite being able to work at greater physical demand level than his pre-injury state, the Respondent chose not to accommodate the Petitioner. Nevertheless, No doctor has stated that the Petitioner cannot work.

"When the employee makes the proper showing, the employer must come forward with evidence to show the employee is capable of engaging in some type of regular and continuous employment, and that such employment is reasonably available." Id. at 362-63. Stated another way, "the claimant has the burden of proving by a preponderance of the evidence the extent and permanency of his injury. Once the claimant has met this burden, then the Respondent must show that some kind of competitive market work is regularly and continuously available to the claimant." Hutson v. Industrial Comm., 223 Ill. App. 3d 706, 714 (5th Dist. 1992).

Respondent has failed to accommodate the Petitioner's new work restrictions despite the fact that they are less restrictive. However, VocaMotive has agreed that the Petitioner is employable. (Pet. Ex. 4) As a result, the Petitioner is capable of engaging is some type of regular and continuous employment and he is not permanently and totally disabled. Not is Petitioner an "odd-lot." Petitioner underwent vocational rehabilitation and did not perform adequately to justify awarding his maintenance benefits after August 3, 2015. (Id.)

Is the Petitioner entitled to a wage-differential award?

There is no requirement under Section 8(d)(1) that a claimant conduct a job search in order to obtain a wage differential award. Rather, claimants need only to demonstrate an impairment of earnings. Albrecht v. Industrial Commission, 271 Ill. App. 3d 756 (1995) However, evidence of a job search is an ideal method to show impairment of earnings. In the present case, as stated earlier, the Petitioner's job search was

unsatisfactory. A labor-market survey is another, perhaps weaker, method to demonstrate an impairment of earning. In the present case, Vocamotive's Kari Stafseth (CRC) initial assessment stated that the Petitioner might be able to return to work with a wage of between $10.00 per hour and $13.00 per hour, but this is not a traditional labor market survey. (Pet. Ex. #4, p. 10). Instead, it was part of an initial assessment and not supported by demonstrated research or data.

At the time of the initial vocational assessment (Pet. Ex. 4), Petitioner was a 56 year old male with permanent light to medium physical restrictions. He graduated from high school in 1976 and received a scholarship to Southern Illinois University. He reported he did not complete his first year in college. However, he received a welding certificate in Industrial Arts and Welding through the University of Houston and held a welding certificate from the American Welding Society. He was certified through Local 1 Blacksmiths-Boilermakers and could perform all types of welding including Arc, MIG, TIG, Horizontal, etc. He received a provisional teaching certificate for welding. He reported owned rental properties. He had work experience as a safety trainer and foreman. He had been a small business owner for a time. (Pet. Ex. 4) Despite all of these skills and qualifications, the initial assessment stated that Petitioner might be able to work with a wage between $10.00 per hour and $13.00. (Id.)

Later, when vocational assessment was fully performed (Pet. Ex. 4 p.35), it was determined that the Petitioner was best suited for the following jobs (among others):

Maintenance Shop Supervisor
Welding Supervisor
Fleet Service Coordinator

Ostensibly, the occupation the Petitioner is most suited for given his age, experience, training and capability would be as a welding instructor or inspector, but the assessment does not state the pay range of such positions, nor of any others listed. In any event, it is difficult to imagine these positions paying less than $13.00 per hour. (Pet. Ex. 4) Respondent did not counter with any evidence that the Petitioner could earn more than $10.00 per hour and $13.00 per hour. But again, the Petitioner earned $43.00 per hour with more onerous pre-accident restrictions.

When inspecting the job search records, it appears that much of the work the Petitioner was encouraged to apply for exceeded the $10.00 to $13.00 hourly pay range and others were within it. (Pet. Ex 4) The jobs within the $10.00 to $13.00 hour pay rate appear to easily obtainable and well within the Petitioner's grasp, yet he failed to apply himself diligently to the task. The final report of Kari Stafseth (CRC) states that if he complied with vocational rehabilitation, he would have had access to positions as dispatcher, customer service representative, and clerk with the most probable earning potential of $10.00 to $13.00 per hour. (Pet. Ex. 4 p.231) The Arbitrator notes these jobs were easily obtainable by the Petitioner and would have been the least competitive, but the lowest paid positions for which he was qualified to work. Stated another way, if the Petitioner had put forth a minimum amount of effort, he could have, at the very least,

found a job in that salary range. The legal standard cannot be the above. The law cannot allow a Petitioner who has suffered a job loss to automatically default into an 8(d)(1) wage differential award when there has been no compliance with vocational rehabilitation and the Petitioner has the education, skills and qualifications to earn significantly more than minimum wage.

The Petitioner is capable earning more than the above. Anthony Kochevar wrote that "Mr. Johnson has a strong background as a welder/fabricator/blacksmith and is an excellent resource in helping veterans understand what would be expected for a career in the trades." (Pet. Ex. 7 p.4) Many jobs the Petitioner appeared qualified for paid more than $10.00 to $13.00 per hour. (Pet. Ex. 7 p.95) A position as a dispatcher at MegaBus USA could be expected to $42,500. A steel dispatcher position was paying $50,000. (Pet. Ex. 7 p.176) The Petitioner seemed ideally suited for a position at Cameron Craig Group that would pay $65,000+. (Pet. Ex. 7 p.191) That job stated the employee would not be installing metal structures (stairs, balconies) but working with customers and would be advising the field installers on field fixes/adjustments. The most important question was, "Do you know welding fabrication and assembly?" (Id.) He applied for an adjunct faculty position at a city college to teaching welding, but the pay rate was not listed. (Id.) Even call centers were paying more than the minimum range. (Pet. Ex. 7 p.92) It is somewhat surprising to the Arbitrator that Petitioner's job search was not focused like a laser on welding inspection and supervising. At trial, the Arbitrator found the Petitioner to be an effective communicator who was fully capable of presenting himself in a professional manner.

After reviewing the above, Petitioner did not meet his burden in showing an impairment of earnings as required by the law under 8(d)(1) of the Act. The Arbitrator specifically rejects the $10.00 to $13.00 per hour estimate as it is clearly the least the Petitioner could be expected to earn. The Petitioner is capable of earning much more. In fact, it is not clear that the Petitioner suffered impairment in earning capacity. His current restrictions are less onerous than his pre-accident state. As a result, the enclosed award defaults to Section 8(d)2 of the Act. To that end, taking into consideration the Petitioner's reported level of impairment, occupation, age, future earnings capacity and disability supported by medical records, the Arbitrator awards 25% loss of use of a person as a whole (job loss) and 25% loss of use of the Petitioner's left leg. No AMA impairment report was in evidence.

(N) Is Respondent due any credit?

The Respondent seeks a credit for all maintenance paid as it perceives the Petitioner's efforts with regard to vocational rehabilitation to be less than diligent.

The petitioner failed to participate in a diligent and good faith job search. Therefore, his claim for maintenance benefits after August 3, 2015 must be denied.

Multiple examples of non-compliance and sabotage on the petitioner's part are detailed in (Pet. Ex 4), the vocational reports, but some of the difficulty includes the following facts.

The petitioner was repeatedly late for his meetings and computer lab. He failed to request time off and failed to put in proper time off sheets. By his own admission, he completed 50% of the weekly required job searches. He was argumentative. He refused to dress properly. He disputed that but there are numerous examples of when he was in jeans, track suits and other inappropriate outfits identified in the vocational reports. He made numerous personal calls during his computer labs. The petitioner refused to make up dates that he missed. He missed appointments for personal court dates, for family issues, for his birthday, for holidays etc. Yet he claims he is dedicated to finding work.

Petitioner turned in job logs. A great deal of his alleged job search was conducted on the internet. He failed to provide confirmation sheets proving that he applied for work on-line. The petitioner lacks credibility with his job search which is similar to lack of credibility about his low back injury and similar to his lack of credibility about injuring his neck and shoulders at work.

The petitioner disputes that he was non-compliance. His litany of excuses became exhausting and unpersuasive after recounting them at length. The petitioner agreed that he was paid maintenance by the respondent in order to compensate him for his time during his job search. However, he did not perform a diligent job search. When asked to make up missed appointments, he was quoted in the vocational reports as saying he had "other responsibilities," which became a mantra.

When there is a lack of "good-faith" cooperation with vocational rehabilitation efforts, the termination of benefits is justified. *Hayden v Industrial Commission, 214 Ill. App.3d 749, 575 NE2d 99, 158 Ill.Dec 305(1st Dist. 1991).* It is the petitioner's obligation to make "good-faith efforts to cooperate in the rehabilitation effort". *Archer Daniels Midland Co. v Industrial Commission, 138 Ill2d 107, 561, NE2d 623, 149 Ill.Dec 253 (1990)*

The Arbitrator finds that the Respondent's termination of maintenance benefits as of August 3, 2015 was long overdue. It is difficult to state the specific moment in time when the Petitioner was noncompliant with vocational rehabilitation. In this case, it is immaterial for the following reason. Not only did Petitioner demonstrate a lack of "good faith" with vocational rehabilitation, he demonstrated a lack of good faith throughout the course of his medical care. For instance, Petitioner had an obligation to inform his doctors of the pre-existing permanent work restrictions that were imposed by Dr. Arnold in 2006, but he failed to do so. His employment duties after 2006 must have changed dramatically as the result of those restrictions, yet he told them that he was working heavy duty when he was injured. The voluminous medical records fail to show an instance where the doctors knew that Respondent had accommodated his sedentary restrictions from 2006 to 2012. If his physicians had known this fact, an FCE might not have been prescribed, as Petitioner would have been returned to his sedentary job. At least some inquiry would have been made about the matter. Further, the Petitioner had an

obligation to inform the functional capacity examiners that he had pre-existing permanent sedentary restrictions, but failed to do so. Moreover, the Petitioner failed to inform the vocational rehabilitation counselor of his pre-existing work restrictions. Additionally, he attempted to claim that his pre-existing low back condition was related to the July 11, 2012 incident and he attempted to claim that his shoulder and neck pain were somehow related to same occurrence. Finally, he could have set the record straight with his testimony at trial, but allowed the trier of fact to assume that he was working with no restrictions on the date of loss. In summary, he had an obligation to act in good faith throughout the course of his medical care and during the pendency of his claim, yet failed to do so. A lie of omission is the intentional failure to tell the truth in a situation requiring disclosure. An example of which could be seller's failure to note a known defect on a real estate disclosure form. The continued misrepresentation occurs when an important fact is left out in order to foster a misconception. Lying by omission includes failures to correct pre-existing misconceptions. In the present case, the Petitioner failed to inform others of his pre-existing permanent sedentary work restrictions. As a result, no maintenance is awarded and Respondent is allowed a credit for all maintenance paid from September 30, 2013 until August 3, 2015.

(O) On what date did Petitioner reach maximum medical improvement?

While that issue is addressed in Paragraph (N) to this Decision, the Arbitrator finds that the date that the Petitioner reached maximum medical improvement was September 30, 2013. At that time, Dr. Cole placed the Petitioner at MMI and stated he had permanent sedentary restrictions. These restrictions match the Petitioner's pre-injury state. The Petitioner worked as a blacksmith for Respondent from 2006 until the date of accident on July 11, 2012, a period of six years with sedentary restrictions.

The date of MMI following the Petitioner's low back surgery was April 7, 2014, but this date is irrelevant, as the lumbar spine component of this claim is not compensable. However, it is interesting to note that the Petitioner's final permanent restrictions (light–medium) allow the Petitioner to work at a higher physical demand level than those written in 2006. These final restrictions were embraced by the vocational rehabilitation counselor of Petitioner's choosing.

As a result of the above, Respondent's maintenance and temporary total disability responsibilities ended on September 30, 2013.

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)
☐ Modify	☐ PTD/Fatal denied
☒ Remand	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jimmie Boatright,

Petitioner,

vs.

NO: 08 WC 43833

The American Coal Company,

17IWCC0036

Respondent.

DECISION AND OPINION ON REMAND

This case comes before the Commission on remand from the Circuit Court for the First Judicial Circuit, Saline County, by means of case number 15-MR-13. On November 28, 2012, Arbitrator Gallagher issued a decision finding that Petitioner did not prove that he suffered from a work related occupational disease and that the Petitioner's condition was not causally connected to his employment. On review, the Commission affirmed and adopted the Arbitrator's decision. The Commission's Decision was then appealed to the Circuit Court of Williamson County where it was remanded back to the Commission to reconsider the issue of causation. On February 9, 2015, the Commission issued a Decision finding that Petitioner sustained an exposure which occurred in the course and scope of his employment with Respondent. The Petitioner was awarded 20% loss of the person as a whole, and found that the Petitioner's average weekly wage was $457.18. That Decision was then appealed and heard by the Circuit Court of Saline County. An Order was issued on December 7, 2015, and then a Modified Order was subsequently issued by the Circuit Court on January 21, 2016. The Modified Order confirmed the finding of exposure by the Commission, vacated the Commission's award of 20% loss of the person as a whole, and remanded the matter for a determination of Petitioner's wage differential claim.

As a result of the Circuit Court's January 21, 2016 Order, the Commission must make a determination on the Petitioner's wage differential claim. The Commission therefore finds that Petitioner is entitled to a wage differential award of $64.79 per week.

FINDINGS OF FACT

Petitioner filed an Application for Adjustment of Claim which alleged that he sustained a work-related occupational disease to his lungs and/or heart as a result of inhalation of coal dust, rock dust, fumes and vapors for a period in excess of 40 years. The date of last exposure alleged in the Application was September 23, 2008.

Petitioner was born in 1932 and, at the time of trial, was 79 years old. From 1965 to 1992 Petitioner worked as a coal miner for various coal companies. He retired from coal mining and began a landscaping business which remains in operation at the time of trial. Petitioner went to work at Bombadier as a security guard in 1995, and in November, 2000, he began working for Respondent as a security guard because of better pay. Petitioner worked for Respondent in that capacity until November 8, 2007, when he was laid off. Petitioner returned to work for Respondent at the request of Bill Winters, Respondent's Chief of Security, on September 22, 2008. Petitioner only worked two shifts for Respondent and his last day of work for Respondent was September 23, 2008, the date of last exposure alleged in the Application.

Petitioner testified that his work as a security guard for Respondent caused him to be exposed to coal mine dust on a daily basis. Petitioner's job duties required him to patrol the area including the bathroom and wash room and drive people from one portal to another by bus. The last two days Petitioner worked for Respondent in September, 2008, he made the rounds in the parking lot and then inside the wash house. Petitioner never worked as a coal miner for Respondent.

Following Petitioner's layoff, he worked as a security guard at The Lighthouse Shelter in Marion, Illinois. Following the cessation of his work for Respondent, he became employed by IRA Detective Agency and worked as a security guard at Bombadier. Petitioner continued to work there up through and including the date this case was tried, making $9.00 per hour.

Petitioner testified that during his 12 hour shifts as a security guard for Respondent, approximately 80% of his time was spent away from the guard shack. He testified that while he worked in the coal mines, he experienced shortness of breath when walking. He first noticed this symptom in the late 1980's when he was working in the prep plants. Petitioner testified his breathing problems got a little bit worse from the time he first noticed them until he left coal mining. When he was working as a guard, his breathing problems would flare up when he had to climb stairs. He did not engaged in this activity the last two days he worked for Respondent. At trial, Petitioner testified he could walk about half a block before becoming short of breath and that he could climb ten to twelve steps before he would have to stop and rest. Petitioner testified that his breathing problems affected his activities of daily living and when this happened, he would either sit down or quit what he was doing for a while. Petitioner testified that, in spite of his breathing problems, he had no intention from retiring from work. Petitioner testified he smoked cigarettes starting at the age of 19 and quit on New Year's Eve, 1978. When he smoked, he smoked an average of a pack a day.

Bill Winters, Chief of Security for Respondent for 31 years, testified on behalf of the Respondent. Mr. Winters testified that Petitioner informed him that he was leaving his job with

Respondent because he did not want to work the 12 hour shifts or night shifts any longer. He did not complain to Mr. Winters about shortness of breath or an inability to perform his job.

Petitioner was examined by Dr. William Houser on February 12, 2009, at the direction of his attorney. Dr. Houser previously took the B-reader course and test to be certified as a B-reader; however, he failed the certification examination. Petitioner informed Dr. Houser that he had complaints of shortness of breath which occurred when walking one block on level ground or climbing two flights of stairs. He also complained of a slight cough which occasionally produced sputum. Petitioner informed Dr. Houser of his prior cigarette smoking and the fact that from 2000 to 2007 he worked for Respondent as a security guard. He further informed Dr. Houser that when he returned to work in September, 2008, he was unable to perform the job due to dust exposure and the physical demands of the job. Dr. Houser testified Petitioner had shortness of breath dating back to 2007. Dr. Houser further testified that there are numerous causes of shortness of breath including heart disease and deconditioning. Dr. Houser testified that given the fact that Petitioner was 76 years of age when he examined him and that he was obese and had heart disease which led to stent placement, that he was not shocked that Petitioner became short of breath after climbing two flights of stairs.

Dr. Houser's examination of Petitioner's chest was normal. Dr. Houser noted that a chest x-ray of July 31, 2008, revealed P/S opacities in all lung zones, category 1/0 pneumoconiosis. Dr. Houser testified that Petitioner's spirometry showed mild airway obstruction based on the FVC/FEV1 ratio but he did not know whether Petitioner's pulmonary function was any different prior to his employment with Respondent than when Dr. Houser measured it on February 12, 2009.

Dr. Houser testified that his diagnosis of coal workers' pneumoconiosis was based upon Petitioner's history of exposure to coal dust and a positive chest x-ray finding and that absent either one of those, he would not have diagnosed coal workers' pneumoconiosis in Petitioner. Dr. Houser testified that Petitioner could not have any further exposure to the environment of a coal mine without endangering his health. He further testified that the scarring and emphysema of coal workers' pneumoconiosis are permanent and they cannot perform the function of normal healthy lung tissue.

Dr. Henry Smith, a NOISH B-reader, interpreted a chest x-ray of May 13, 2008, as positive for pneumoconiosis with P/S opacities in the mid to lower lung zones bilaterally and profusion of 1/0. He interpreted a chest x-ray of July 31, 2008, as positive for coal workers' pneumoconiosis with interstitial fibrosis and P/S opacities in all lung zones with a profusion of 1/1. Dr. Smith interpreted a CT scan of May 13, 2008, as consistent with simple coal workers' pneumoconiosis with P/S opacities in the mid to lower lung zones bilaterally and a profusion of 1/0. Dr. Smith interpreted a chest x-ray of November 6, 2008, as early mild simple coal workers' pneumoconiosis with P/P opacities in the bilateral mid to lower lung zones and a profusion of 1/0. He made a similar interpretation of a CT scan of that same date.

At the request of Respondent, Dr. Jerome Wiot, a B-reader, reviewed chest x-rays regarding Petitioner. Dr. Wiot reviewed a chest x-ray and CT scan dated May 13, 2008, chest x-ray dated July 31, 2008, and a chest x-ray dated November 6, 2008, as well as a CT scan of that

same date. Dr. Wiot found no evidence of coal workers' pneumoconiosis in any of these diagnostic studies. Dr. Wiot noted the study of May 13, 2008 revealed a non-calcified nodular density at the right base and a non-calcified nodule at the left base; however, he testified that those findings were not associated with Petitioner's dust exposure.

At the request of Respondent, Dr. Lawrence Repsher conducted a review of medical records and films regarding the Petitioner. Dr. Repsher is a certified NOISH B-reader. Dr. Repsher reviewed a chest x-ray dated July 31, 2008, a CT scan dated May 13, 2008, and found no evidence of coal workers' pneumoconiosis on these diagnostic studies. Dr. Repsher testified that the medical records he reviewed regarding Petitioner revealed the presence of heart disease and that this is the most common cause of shortness of breath. Dr. Repsher opined Petitioner has never suffered from coal workers' pneumoconiosis or any other respiratory disease or condition either caused or aggravated by the inhalation of coal mine dust. He further testified Petitioner has no functional limitation from the pulmonary standpoint based upon the testing he reviewed.

Petitioner underwent VATS resection of a benign necrotic tumor in the right lower lobe of his lung in June, 2008. Dr. Repsher testified there were no coal macules seen in the biopsy specimen from the right lower lobe. He testified that it would be very unlikely that there would be any coal macules elsewhere in the lungs.

Medical records of Dr. Albert Bledig were received into evidence. Petitioner had balloon angioplasty performed in February 1991 for coronary artery disease and he described no shortness of breath at the time of the examination on January 18, 1993. On November 6, 1996, it was noted that Petitioner had occasional shortness of breath, but he weighed 238 pounds at that time. Examination of the lungs revealed no rales. On a physical examination on November 27, 1997, Dr. Bledig noted Petitioner did not have shortness of breath. On the August 22, 2007, examination, Petitioner's lung were clear with no wheezing or crackles. Physical examinations conducted on September 20, 2010, and August 11, 2011, revealed Petitioner's lungs to be clear.

Medical records of St. Mary's Medical Center were received into evidence. These records included records from the Welborn Baptist Hospital. On February 20, 1991, Petitioner was hospitalized at Welborn with a three week history of chest pain associated with shortness of breath. The medical record there revealed Petitioner was a smoker having smoked a pack a day for over 30 years. An examination of Petitioner's lungs determined that they were clear. A CT of the abdomen taken on May 1, 2008, revealed a non-calcified pulmonary nodule at the base of the right lung. On June 4, 2008, Petitioner underwent a flexible fiber optic bronchoscopy for the right lower lobe lung nodule. The microscopic description of the pathology report noted a chronic nodule surrounded by fibrotic hyalinized lung. The lung area remote from the nodule had scattered fibrosis, inflammation and emphysematous changes, but no other specific findings. The discharge summary listed smoking as a diagnosis.

Further medical records of Prairie Cardiovascular were received into evidence. On June 25, 1999, Petitioner was admitted to St. John's Hospital with a complaint of unstable angina. It was at this time that Petitioner underwent a cardiac catheterization which revealed severe coronary artery disease. The Petitioner underwent a successful coronary stenting of the right coronary artery. It was noted in connection with that hospitalization that his lungs were clear.

Subsequent examinations conducted on March 8 and August 22, 2001 revealed that his lungs were clear.

CONCLUSIONS OF LAW

Per the direction of the Circuit Court's May 30, 2014 Order, the Commission finds that Petitioner sustained an exposure in the course and scope of his employment with Respondent as a matter of law.

Per the direction of the Circuit Court's January 21, 2016 Order, the Commission vacates its previous award of 20% loss of the person as a whole, and finds that Petitioner is entitled to a wage differential award per Section 8(d)1 of the Act. The Commission further finds Petitioner's wage differential award to be $64.79 per week.

We find that Petitioner's exposure is causally connected to his last employment. Petitioner worked for various coal companies for approximately 40 years, and as recently as 2008. While Petitioner admitted to smoking one pack of cigarettes a day for about 20 years, he quit smoking in the 1980s. He spent a significant amount of time surrounded by and exposed to coal dust and other associated hazards. Petitioner testified that he worked above ground in the mining area. Even though he did not spend his days below ground in the mine itself, Petitioner was still exposed to all of the airborne hazards of a coal mine and inhaled coal dust and other particles that were brought to the surface by miners and equipment.

The Act provides a presumption that the cause of Petitioner's coal workers' pneumoconiosis was his work at the coal mines. The Act provides: "If a miner who is suffering or suffered from pneumoconiosis was employed for 10 years or more in one or more coal mines there shall, effective July 1, 1973 be a rebuttable presumption that his or her pneumoconiosis arose out of such employment." 820 ILCS 310/1(d). Petitioner met that presumption and Respondent has failed to rebut it.

Further, we find Petitioner's average weekly wage was $457.18. Petitioner submitted evidence into the record that in 2007, the last year that he worked for Respondent, he earned $23,773.31. When his salary of $23,773.31 is divided by 52 weeks, it equals $457.18.

The Commission further finds that Petitioner's wage differential award should be $64.79 per week under Section 8(d)1 of the Act. At the time of trial, the Petitioner was able to earn $360.00 per week ($9.00 per hour for 40 hours). The difference between the Petitioner's mining wages ($457.18) and what he currently earns ($360.00) is $97.18. Two-thirds of the difference between what the Petitioner earned in his employment and what he is currently earning equals $64.79. Therefore, the Petitioner's wage differential award is $64.79.

IT IS THEREFORE ORDERED BY THE COMMISSION that Decision of the Commission filed on December 20, 2013 is modified as stated above.

17IWCC0036

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner a wage differential award of $64.79 under Section 8(d)1 of the Act.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $28,000.00. 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 24 2017

TJT/ gaf
O: 10/25/16
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

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

Darlene Huntinghouse,

Petitioner,

vs. NO: 13WC 13229

City of Elmhurst,

17IWCC0037

Respondent,

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 16, 2015, is hereby affirmed and adopted.

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

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

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

The party commencing 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 24 2017
o011817
CJD/jrc
049

Charles J. DeVriendt

Joshua D. Luskin

Ruth W. White

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HUNTINGHOUSE, DARLENE
Employee/Petitioner

Case# **13WC013229**

CITY OF ELMHURST
Employer/Respondent

17IWCC0037

On 10/16/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

4036 MILLON & PESKIN LTD
MITCHELL PESKIN
2100 MANCHESTER RD SUITE 1060
WHEATON, IL 60187

0445 RODDY LAW LTD
RICHARD S ZENZ
303 W MADISON ST SUITE 1900
CHICAGO, IL 60606

17IWCC0037

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

Darlene Huntinghouse
Employee/Petitioner

v.

City of Elmhurst
Employer/Respondent

Case # **13** WC **13229**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Jessica Hegarty**, Arbitrator of the Commission, in the city of **Elgin**, on **July 14, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [ ] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [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. [ ] 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 **Whether the Petitioner is entitled to prospective medical care?**

FINDINGS

On **February 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* 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 $**85,603.96**; the average weekly wage was $**$1,646.23**.

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

Petitioner ***has not*** received all reasonable and necessary medical services.

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

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

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

ORDER

- **The Arbitrator finds that Petitioner's left foot and right shoulder condition are causally connected to her 2/3/13 work accident;**
- **Respondent shall pay the reasonable and necessary medical services, pursuant to the medical fee schedule, for those providers listed in Petitioner's Exhibit 7, as provided in Sections 8(a) and 8.2 of the Act.**
- **The prospective surgery prescribed by Dr. Arndt is awarded. Accordingly, Respondent shall pay the reasonable and necessary medical services associated with the 2/3 neuroma surgical resection prescribed by Dr. Arndt, treatment for her left hammertoe, and any other reasonable and necessary medical or prescription expenses related thereto, as provided in Sections 8(a) and 8.2 of the Act.**

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

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

Signature of Arbitrator

9/29/15
Date

OCT 16 2015

BEFORE THE WORKERS' COMPENSATION COMMISSION
OF THE STATE OF ILLINOIS

DARLENE HUNTINGHOUSE,	)	
	)	
Petitioner,	)	
	)	
vs.	)	**No. 13 WC 13229**
	)	
CITY OF ELMHURST,	)	Kane County
	)	
Respondent.	)	

17IWCC0037

This matter was heard before Arbitrator Jessica Hegarty on July 14, 2015, in Elgin, Illinois. The parties stipulated to all issues except:

- Causal connection;
- Unpaid medical bills;
- Prospective medical treatment. (Arb. 1).

ADDENDUM TO THE DECISION OF THE ARBITRATOR

Findings of Fact

Petitioner has been employed by Respondent as a firefighter/EMT for approximately 21 years. Her job duties include, responding to calls for rescues and fires, assisting police and performing inspections of buildings.

When she is out on service calls she is required to wear fire gear consisting of boots, bunker paints, fire coats, gloves, helmet and a Nomex hood. The mode of transportation taken for service calls is either a fire truck or fire engine.

It is undisputed that on February 3, 2013, the Petitioner (then 49-years-old) sustained accidental injuries that arose out of her employment with the Respondent as a firefighter/EMT. (Id.) On that date, Petitioner was responding to a crash on Route 38 in Elmhurst, Illinois. She arrived at the scene via fire truck, wearing her full fire gear. The Petitioner exited the fire truck, from the passenger's side while holding onto a handle on the side of the truck. The floor of the truck was about three and half feet off the ground. As she was backing down out of the truck her left foot slipped, rolled and twisted on the icy pavement, she was still holding onto the truck handle at the time. Consequently, her right arm bore her full body weight as her right foot was not on the ground at the time she slipped. The Petitioner testified that only the ball of her left foot had touched the ground at the time she twisted and rolled it.

Petitioner testified that she experienced significant pain at the ball of left foot and on the outside edge of her left foot. She further testified to pain in her right shoulder that radiating up into the right side of her neck. She testified that she was unable to perform any work at that service call and did not leave the side of the truck because she could not bear weight on her left foot.

The Petitioner reported the accident to her lieutenant, Mark Millet on February 12, 2013. She testified that she did not report the accident earlier because she was hoping her pain would resolve. According to her testimony, she was also afraid of being relegated to light duty work as a consequence of reporting the injury. The Arbitrator notes that notice is not disputed.

On February 14, 2013, the Petitioner's sought treatment with her primary care doctor, Dr. Ghori Kahn who noted a history of right shoulder and left foot complaints after attempting to exit a fire truck. (PX3). Dr. Kahn noted tenderness at the 4th and 5th metatarsals of Petitioner's left foot as well as right shoulder pain. Dr. Kahn diagnosed the Petitioner with metatarsalgia (pain in the metatarsal heads) and a shoulder sprain. Petitioner was prescribed physical therapy for her right shoulder, and referred her to a podiatrist for her left foot complaints. (Id.)

On May 3, 2013, Petitioner presented to Dr. Shane York, a podiatrist, for initial evaluation. (PX 4) The doctor noted Petitioner "has pain that has been present since the injury occurred in January while on the job when she slipped getting out of a firetruck." (Id.) Petitioner complained of pain to the lateral aspect of her left foot that the doctor noted was reproducible along the peroneal tendon. (Id.) X-rays of the left foot were unremarkable for any acute findings. (Id.) The doctor diagnosed Petitioner with peroneal tendinitis "likely after an inversion-type injury." (Id.) Petitioner was fitted with a temporary orthotic and instructed to take Aleve twice daily. (Id.) The doctor noted an MRI of the mid foot may be necessary if Petitioner's condition failed to improve at her follow-up appointment in the next 2-3 weeks (Id.)

On May 17, 2013, Dr. York noted the Petitioner presented reporting "25% improvement" over the last two weeks while utilizing the temporary orthotic and taking Aleve. (Id.) On exam, the doctor noted hyperkeratotic buildup to the plantar second and third metatarsal parabola. (Id.) He diagnosed the Petitioner with improved peroneal tendinitis and callusing to the padding of the forefoot with a pes cavus foot structure. (Id.) Dr. York advised Petitioner to continue with the orthotic treatment and to follow-up in one month. (Id.)

On July 19, 2014, Dr. York noted the Petitioner's complaints of left foot focal pain with direct palpation of the plantar aspect of the second metatarsal head as well as to the base of the toe. He diagnosed the Petitioner with "[a]cute-on-chronic pain to the plantar aspect of the second metatarsal head with an underlying pes cavus foot structure and a probable predislocation syndrome involving the second metatarsophalangeal joint." (Id.) Dr. York recommended a left foot MRI to evaluate the plantar plate and second metatarsophalangeal joint and to rule out a stress fracture. The doctor

instructed her to return with the temporary orthotics so he could "place a second metatarsal cutout, as well as metatarsal pad." (Id.)

On July 25, 2013, Petitioner underwent a left foot MRI at Midwest Orthopaedic Institute. (Id.) The MRI showed:

- *A small 2nd metatarsophalangeal joint effusion without evidence of significant joint degeneration. No evidence of tear of the plantar plate";*
- *Mild DJD of the first MTP joint with tear of the central aspect of the plantar plate; and*
- *Mild DJD of the first tarsometarsal joint.* (Id.)

On September 4, 2013, Petitioner returned to Dr. York to review the MRI. (Id.) Petitioner's complaints of severe discomfort in her left foot were noted. (Id.) Dr. York noted the left foot MRI showed joint effusion of the second metatarsophalangeal joint without any history of severe trauma. The doctor instructed Petitioner to take Aleve twice a day and follow-up to ascertain whether a custom orthotic should be cast. (Id.)

The Petitioner thereafter sought treatment with an orthopedic doctor, Dr. Stephen Arndt, whom she consulted with initially, on December 8, 2013. (PX5). The doctor noted complaints of continuing pain in the "2-3 interspace" of her left foot. (Id.) Petitioner reported she had noticed her toes widening and that she had "developed a mild hammertoe." (Id.) The doctor performed a Lidocaine, Marcaine and steroid injection into the Petitioner's 2/3 interspace. (Id.)

On December 26, 2013, Dr. Arndt noted that Petitioner reported doing much better. (PX5) The doctor recommended ice and anti-inflammatory medication. (Id.).

The Petitioner returned to see Dr. Arndt on October 20, 2014 with complaints of increased pain in the ball of her left foot. (Id.) Dr. Arndt noted that the Petitioner had a 2/3 neuroma on the left side of the foot from an injury at work. The doctor further noted that despite undergoing an injection, ice, anti-inflammatories and some exercises, Petitioner's complaints were ongoing. (Id.) Dr. Arndt offered the Petitioner another injection. (Id.) The Petitioner testified that she did not want to go through the pain of another injection. Dr. Arndt suggested a surgical resection of the 2/3 neuroma after Petitioner requested treatment that would offer permanent relief. (Id.)

At the request of the Respondent the Petitioner attended a Section 12 examination with Dr. Coe on October 7, 2014. Dr. Coe noted the Petitioner's complaints of constant, throbbing pain in the sole of her the left foot which was made worse with prolonged standing or walking. (RX1; Pg. 46-48 & EX. 2).

Dr. Coe noted the Petitioner had a slight gait abnormality marked by limited weight bearing in the left forefoot region. (RX1; Pgs. 21, 48 & EX. 2). He also found tenderness on the plantar aspect of the left second and third metatarsal heads. (RX1; Pgs. 21, 48 & EX. 2). He noted movement of her left toes was associated with some pain at the metatarsal phalangeal joint. (RX1; Pg. 22 & EX. 2).

The Petitioner last saw Dr. Arndt on June 17, 2015. The doctor noted that the Petitioner's neuroma was still producing pain and that she had developed a hammertoe. (RX5). He opined that the neuroma caused a little bit of weakening of the capsule because her second and third toes were spreading resulting in the hammering of that toe. (RX5). He prescribed a hammertoe dressing. (RX5). The Petitioner testified she is using the hammer toe dressing and it has not been helping.

The Petitioner testified that she has continued to work full duty for the Respondent as a firefighter/EMT and has not been prescribed any work restrictions. She testified that she has constant pain in her left foot which causes her difficulty while working. Specifically, she has trouble stepping up into the rig, climbing a ladder, being on her feet for a long time and doing a lot of walking. The Petitioner testified her pain in her left foot is continuous. When she lifts her feet up at night to go to bed, her left foot throbs. During the day it hurts and feels like she is walking on a pebble. She testified that she cannot jog and that she is very limited in her workouts.

Prior to her February 3, 2013 accident the Petitioner never treated for nor had any injuries to her left foot.

The Petitioner testified that Dr. Arndt discussed the proposed surgical resection of the 2/3 neuroma in her left foot and that she wants to have the surgery in order to have a permanent solution for her left foot pain.

With respect to her right shoulder, following her visit with Dr. Kahn, the Petitioner treated with Dr. Glasgow on May 2, 2013. (Id.) She testified that at that time she was having pain with movement and weakness in right shoulder. Dr. Glasgow noted a history of pain in the right shoulder after slipping on ice and using her right arm to catch herself. (Id.). He further noted that the Petitioner denied any prior issues regarding her right shoulder. (Id.) During the examination Petitioner reported throbbing pain primarily at the superior aspect of her right shoulder. (Id.) It was noted that Petitioner had been taking Naproxen, and was difficulty sleeping at night because of the pain. (Id.) Dr. Glasgow found that the Petitioner had tenderness at the AC joint, positive cross-body on the right side without impingement findings, positive liftoff and belly press, weak bear hug consistent with subscapularis tearing, positive Speed's, positive supraspinatus stress testing, positive O'Brien's, and diminished and painful strength on the right. (Id.) Dr. Glasgow diagnosed the Petitioner with right shoulder rotator cuff weakness following a history of injury. (Id.) He prescribed an MRI of the right shoulder. (Id.)

An MRI was performed on Petitioner's right shoulder on May 3, 2013. (Id.) The report reflected a tiny low grade partial interstitial tear at the supra/infraspinatus junction, prominent juxta-articular osseous edema about the AC joint which may relate to AC joint sprain and/or reactive change associated with mild osteoarthritis, and minimal subacromial subdeltoid bursitis. (Id.)

On May 10, 2013 Dr. Glasgow informed the Petitioner of the MRI results and recommended consideration of a cortisone injection and physical therapy. (Id.).

The Petitioner testified that she did not have the physical therapy or the injection because she did not want to be put on light duty.

The Petitioner returned to Dr. Glasgow on July 22, 2013. (Id.) He noted the patient did not go to therapy and was taking Aleve as needed. (Id.) He also noted her pain was less and that she has been self-modifying her activities. (Id.) The Petitioner had reported a warm feeling with use of her right arm with raising and she rated her pain at a 6 out of 10. (Id.) Dr. Glasgow diagnosed the Petitioner with a partial rotator cuff tearing of the right shoulder post injury. He recommended therapy again for her shoulder, but noted that because of the Petitioner's time constraints, he printed for her home exercises and gave her Thera-Bands. (Id.) He was no longer recommending a cortisone injection because of her improved complaints. (Id.) He recommended continue use of over-the-counter anti-inflammatories as needed. (Id.)

The Petitioner testified that she did perform the exercises that were provided to her by Dr. Glasgow.

When the Petitioner saw Dr. Coe on October 7, 2014, he noted that she continued to experience some stiffness and pain into her right shoulder and neck. (PX1, EX. 2). He did not find any focal abnormalities of the shoulder. (Id.)

The Petitioner testified her right shoulder is weaker since the accident. When working, she has difficulty holding on to the handle to pull herself up and back down out of the rig; something she does repetitively. Prior to her February 3, 2013 accident the Petitioner never treated for nor had any injuries to her right shoulder.

Evidence Deposition of Dr. Coe

Dr. Coe sat for an evidence deposition on October 7, 2014. (RX1). Dr. Coe testified he is a board certified specialist in occupational medicine. (Id., Pg. 6). Dr. Coe testified that a neuroma is a swelling or inflammation of a nerve down in the front of the foot usually between the metatarsal heads. (Id.,Pg. 18). Symptoms of a neuroma are usually an electrical, sharp or nerve type pain that is localized. (Id., Pg. 51-52). With this condition pain can occur stepping down onto the front of the foot and is usually made worse by walking on your toes, climbing up stairs and jumping down on the foot. (Id., Pg. 52). Dr. Coe testified that a trauma such as a crush injury, penetrating wound or chronic repetitive trauma; can cause a neuroma to develop. (Id., Pg. 51). According to his testimony, a foot neuroma can be diagnosed by an MRI. (Id., Pg. 25). He testified the MRI report showed no masses in the Petitioner's left forefoot, but he acknowledged he did not review the actual MRI images. (Id., Pgs. 16, 25, 43-44). Dr. Coe testified he believed the Petitioner strained her left foot and had some tendonitis as a result of her work accident. (Id., Pg. 51). He stated that there is no causal relationship between her

accident and her left forefoot metatarsal phalangeal joint pain. (Id., Pg. 24). He also testified that the neuroma is not something that would arise from the twisting of the foot. (Id.) It was his opinion that the Petitioner's condition is something that is seen in individuals with pes cavus (a fixed high arch). (Id., Pg. 12, 24). Dr. Coe's opinion was based in part on what he believed was a gap in time in the diagnosis of the condition (neuroma) and on a delayed ("months following the accident at work") reporting by the Petitioner of the onset of left foot pain. (Id., Pg. 26). He was incorrectly under the impression that the Petitioner's accident was in December 2012 and that she did not treat for her left foot until May 17, 2013. (Id., Pgs. 35, 37-38).

Dr. Coe was under the impression that Dr. Arndt was a podiatrist. (Id., Pgs. 17, 42). During his deposition he acknowledged that he did not know that Dr. Arndt was actually a general orthopedic doctor with a specialty focus in treating complex problems of the knee, foot and ankle both non-operatively and surgically. (Id., Pg. 42). Dr. Coe agreed that given Dr. Arndt's medical specialty that it was reasonable for the Petitioner to have treatment with him for her left foot. (Id., Pg. 43). He further testified that exploratory surgery for the Petitioner's left foot might be a reasonable treatment option and that it would be best to defer the decision regarding that type of surgery to an orthopedic foot and ankle specialist. (Id., Pgs. 38, 39-40).

Regarding the Petitioner's right shoulder condition, Dr. Coe testified that she strained it as a result of the accident when she slipped on the ice. (Id., Pg. 35). He opined that the she did not have any significant injury to her right shoulder from the accident. (Id., Pg. 44-45). However, Dr. Coe admitted he never reviewed the MRI report or film of the Petitioner's right shoulder and did not review any medical records pertaining to treatment the Petitioner had for her right shoulder. (Id., Pg. 43-46). He also testified that it is possible his opinion would change if there were additional medical records showing pathology to the Petitioner's right shoulder. (Id., Pg. 46).

Evidence Deposition of Dr. Stephen Arndt

Dr. Stephen Arndt was deposed on March 25, 2015. (PX6). Dr. Arndt is an orthopedic surgeon who specializes in treating the foot and ankle (Id., Pg. 5). He completed a fellowship in foot and ankle orthopedic surgery. (Id.). Seventy-five percent of his practice involves treatment for foot and ankle conditions. (Id.). He performs approximately 550 foot and ankle related surgeries per year. (Id., Pgs. 5-6). Dr. Arndt testified that a neuroma is nerve inflammation in an area of the foot which is like a pinched or irritated nerve that is causing pain and symptoms (Id., Pgs. 9-10). Dr. Arndt testified that a neuroma can be caused by injury to the foot that can cause swelling or tissue damages. (Id., Pg. 11) The swelling can irritate the nerve and even after the swelling has gone away, the nerve can stay irritated. (Id., Pg. 11) Dr. Arndt testified that an MRI is not an appropriate diagnostic tool to determine or diagnose a neuroma. (Id., Pg. 31, 43). Diagnosis is based on history and clinical examination. (Id., Pg. 31). Dr. Arndt testified that the left foot MRI that did not identify neuromata is to be expected.

(Id., Pgs. 32-33). He also testified that ultrasound and x-rays are not very good at picking up neuromas. (Id., Pg. 31). According to Dr. Arndt, a cortisone injection (besides its therapeutic value) is probably the best diagnostic test for neuroma. (Id., Pgs. 12-13). Dr. Arndt testified that the fact that the Petitioner was doing better after the injection confirmed the diagnosis of a neuroma. (Id., Pg. 14). Further, he opined that the findings on the MRI of joint swelling in the second MTP and increased fluid suggested some element of trauma. (Id., Pg. 37). These findings themselves, could be a causative factor of a neuroma and could explain why the Petitioner was having symptoms in that area. (Id., Pg. 42-43).

Dr. Arndt testified that with an ankle sprain a person commonly can get an evulsion type injury at the base of the fifth metatarsal and peroneal tendon pain in that area. (Id., Pg. 34). He stated that with a twisting injury usually the whole foot rolls and a spectrum of injuries can occur. (Id., Pg. 34). Accordingly to Dr. Arndt, ninety percent of inversion type injuries resolve within a period of four to six weeks, and if there is no such resolution this could be indicative of a soft tissue injury, a tendon injury or ligament tearing. (Id., Pg. 36).

Dr. Arndt testified that Dr. York's diagnosis of peroneal tendonitis is consistent with the type of trauma the Petitioner had sustained. (Id., Pg. 25-26). He also testified that Dr. York's reference to pain at the second metatarsal phalangeal joints is exactly where the 2/3 interspace is located. (Id., Pg. 30). Although it was not documented as a neuroma, Dr. Arndt testified that Dr. York's note of pain with the second metatarsal phalangeal joint is consistent with pain from a neuroma. (Id., Pgs. 41-42). Dr. Arndt opined that it is more probably than not that the pain Dr. York was describing as MTP pain is the same pain that Dr. Arndt was describing as neuroma pain. (Id., Pg. 44, 45). Dr. Arndt testified that he believed the Petitioner had a neuroma or a pinched nerve in her left foot and that the accident was the causal irritant of the Petitioner's left foot condition. (Id., Pgs. 9, 24). He opined that the accident aggravated, exacerbated and irritated her left foot condition. (Id., Pg. 24). His opinion was based in part on the fact that the Petitioner did not have any preceding history of pain in that area and that since that event she has had a persistent element of discomfort, with no other inciting events. (Id., Pgs. 24-25, 41).

Dr. Arndt testified that surgery is a reasonable option for the Petitioner. (Id., Pgs. 17, 21-22). He opined that the Petitioner has a neuroma based on her response to the injection. Given the Petitioner's failure to obtain relief from ice, anti-inflammatories, changing shoes, and using inserts; Dr. Arndt opined the next logical step would be to perform a surgical excision of the neuroma and removing the nerve. (Id., Pgs. 21-22, 23). He further opined that the Petitioner's need to undergo the surgery was necessitated in part by her work accident. (Id., Pg. 25).

Dr. Arndt recommended a surgery to cut out a section of the nerve in the 2/3 interspace. (Id., Pg. 17). Dr. Arndt testified it would be an out-patient procedure and would take approximately fifteen minutes. (Id., Pg. 18). Post-operative treatment would involve

keeping the Petitioner in a shoe or boot for the first three to four weeks until the skin heals and allowing weight bearing as tolerated. (Id., Pg. 18, 19). If the Petitioner had the surgery, Dr. Arndt testified that she would not be working in the first three to four weeks and her return to work would be depending on how she felt. (Id., Pg. 20-21).

CONCLUSIONS OF LAW

F. Whether Petitioner's Present Condition of Ill-being is Causally Related to the Injury, the Arbitrator makes the following findings:

The Arbitrator notes Petitioner's unrebutted testimony that prior to the work accident at issue, she had never treated for nor had an injury to her left foot. The Arbitrator also notes that since her injury the Petitioner's left foot pain has been in the same location, has never resolved and continues to worsen. If the Petitioner simply had an inversion type injury or sprain as Dr. Coe suggested, the evidence establishes that it should have resolved within four to six weeks following the accident. In the present case, this did not happen which in itself is indicative that Petitioner had a more serious injury than what Dr. Coe believed.

The diagnosis of neuroma was confirmed by the Petitioner's response to the diagnostic/therapeutic injection. Although the MRI did not reveal a neuroma, as Dr. Arndt stated, it should not have because MRI is not an appropriate diagnostic tool for that type of condition. In fact, if anything, the findings of increased fluid and swelling at the second MTP joint were indicative of a trauma and could have been a cause of the neuroma condition.

Dr. Arndt's testimony established that the accident was the cause of the Petitioner's left foot condition. Although Dr. Coe opined that there was no such causal relationship, part of his opinion was based on his understanding that the Petitioner waited months after her accident to first treat. He seemed unaware that the Petitioner's accident happened on February 3, 2013 and that she first treated nine days later on February 12, 2013. He also believed Dr. Arndt was a podiatrist and was unaware that he was an orthopedic surgeon. Moreover, Dr. Coe himself is an occupational medicine specialist, does not specialize in treatment of the foot and ankle and is not board certified in orthopedic surgery. Whereas Dr. Arndt is board certified in orthopedic surgery and specializes in the treatment of foot ankle conditions.

Given the above, the Arbitrator finds the opinions and conclusions of Dr. Arndt to be more credible and persuasive than those of Dr. Coe. Accordingly, the Arbitrator finds that the nature of the Petitioner's left foot condition is a 2/3 neuroma and a developing hammertoe. Upon review of all of the evidence cited herein, including the credible testimony of the Petitioner, the Arbitrator concludes that the Petitioner's left foot condition is causally related to her February 3, 2013 work accident.

In addition to injuring her left foot, the evidence shows Petitioner injured her right shoulder at the time of her accident. Her testimony and the medical records establish that she had shoulder pain immediately following her injury which continued on throughout her treatment. Prior to her accident she had never injured or treated for her right shoulder. Her testimony further establishes that her condition never fully resolved. She continues to notice her right shoulder is weaker and has difficulty holding on to the handle of the fire truck in order to pull herself up and down.

Although, Dr. Coe testified that the Petitioner only strained her shoulder as a result of the accident, he had never reviewed the May 3, 2013 MRI report or imaging. He also never reviewed any medical records pertaining to the Petitioner's treatment for her right shoulder. He admitted his opinions could change if there was additional medical records showing pathology to the Petitioner's right shoulder. The Arbitrator notes there indeed was such evidence. The May 3, 2013 MRI confirmed that the Petitioner had a partial tear at the supra/infraspinatus junction, evidence of an AC joint sprain and subacromial subdeltoid bursitis. Following the MRI, her orthopedic doctor, Dr. Glasgow diagnosed her with a partial rotator cuff tearing of the right shoulder post her work accident.

Based upon the foregoing, and having considered the totality of the credible evidence adduced at hearing, the Arbitrator finds that the Petitioner sustained a partial rotator cuff tear and that this condition is causally related to the Petitioner's February 3, 2013 work accident.

J. Whether the Medical Services that Were Provided to Petitioner Were Reasonable and Necessary; the Arbitrator makes the following findings:

The Petitioner submitted into evidence as Petitioner's Exhibit 7 the following medical bills:

Provider	D/S	Amount	Body Part
DuPage Medical Group - Dr. Arndt	6/17/2015	$157.00	Left Foot
DuPage Medical Group - Dr. Arndt	12/8/2014	$147.00	Left Foot
DuPage Medical Group - Dr. Arndt	10/20/2014	$157.00	Left Foot
DuPage Medical Group - Dr. Arndt	12/9/2013	$188.00	Left Foot
DuPage Medical Group - Dr. Arndt	12/9/2013 & 12/26/13	$599.00	Left Foot
Midwest Orthopaedic Institute - Glasgow	5/2/2013	$171.00	Right Shoulder
Midwest Orthopaedic Institute - Glasgow	5/2/2013	$182.00	Right Shoulder
Midwest Orthopaedic Institute - York	5/3/2013	$70.00	Left Foot
Midwest Orthopaedic Institute - York	5/3/2013	$182.00	Left Foot
Midwest Orthopaedic Institute -York	5/3/2013	$128.00	Left Foot
Midwest Orthopaedic Institute - MRI	5/3/2013	$2,923.00	Left Foot
Midwest Orthopaedic Institute - Dr. York	5/17/2013	$168.00	Left Foot
Midwest Orthopaedic Institute - Dr. York	7/19/2013	$168.00	Left Foot
Midwest Orthopaedic Institute - Glasgow	7/22/2013	$168.00	Right Shoulder
Midwest Orthopaedic Institute - MRI	7/25/2013	$2,771.00	Left Foot
Midwest Orthopaedic Institute - Dr. York	9/4/2013	$168.00	Left Foot
KishHealth	2/14/2013	$100.00	Left Foot, Right Shoulder

The Petitioner's testimony and the medical evidence, including the testimony of Dr. Arndt, established that the above-referenced bills correspond to treatment the Petitioner had for her left foot and right shoulder conditions. The Respondent disputed payment of these bills based on liability and provided no evidence disputing the reasonableness of these charges.

Based upon the above and the Arbitrator's findings on causal connection, the Arbitrator finds that the Petitioner is entitled to receive from the Respondent compensation for the above listed bills pursuant to paragraph (a) of Section 8 of the Illinois Workers' Compensation Act and in accordance with current fee schedule pursuant to Section 8.2 of the Act.

O. Whether the Petitioner is Entitled to Prospective Medical Care, the Arbitrator makes the following findings:

In reviewing the evidence the Arbitrator notes it has been over two years since the Petitioner's accident and she continues to suffer left foot pain. She has participated in conservative treatment in the form of orthotics, anti-inflammatory medication and injections, without any lasting relief. Presently, her left foot pain limits her ability at work by causing her trouble stepping up into the fire truck, climbing a ladder, being on her feet for a long time and doing a lot of walking. Her pain also limits her ability to perform activities outside the work environment. When off her feet the Petitioner feels throbbing foot pain and when she is on her feet, she feels like she is walking on a pebble.

In light of her failed conservative treatment, she has been prescribed a surgical resection of the nerve in the 2/3 interspace of her left foot by Dr. Arndt as an option for permanent relief of her symptoms. The Petitioner discussed with Dr. Arndt what is involved with the surgical procedure and testified she would like to have it in order to have a permanent solution for getting rid of the pain she continues to experience.

Dr. Coe testified that exploratory surgery for the Petitioner's left foot might be a reasonable treatment option and that it would be best to defer the decision regarding that type of surgery to an orthopedic foot and ankle specialist. Upon learning that Dr. Arndt is an orthopedic doctor during cross examination, Dr. Coe conceded it was reasonable for the Petitioner to treat with him for her left foot.

The Arbitrator notes that based on the evidence it appears unlikely the Petitioner's condition will improve without surgery.

Based upon the foregoing, and having considered the totality of the credible evidence adduced at hearing, the Arbitrator finds that the surgical procedure Dr. Arndt has prescribed for the Petitioner is reasonable, necessary and causally related to the Petitioner's February 3, 2013 accident. Pursuant to Paragraph (a) of Section 8 of the Illinois Workers' Compensation Act, the Arbitrator orders the Respondent to authorize and pay for a 2/3 neuroma surgical resection, treatment related to the Petitioner's left hammertoe, and any other reasonable and necessary medical or prescription expenses related thereto.

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

Anthony Molenda,
Petitioner,

vs.

NO: 13WC 22024

17IWCC0038

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 21, 2015, is hereby affirmed and adopted.

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

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

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

DATED: JAN 24 2017
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CJD/jrc
049

Charles J. DeVriendt

Joshua D. Luskin

Ruth W. White

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MOLENDA, ANTHONY
Employee/Petitioner

Case# **13WC022024**

14WC004876

CENTRAL GROCERS
Employer/Respondent

17IWCC0038

On 10/21/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.11% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0293 KATZ FRIEDMAN EAGLE ET AL
DAVID M BARISH
77 W WASHINGTON ST 20TH FL
CHICAGO, IL 60602

3998 ROSARIO CIBELLA LTD
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JOLIET, IL 60432

17IWCC0038

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

Anthony Molenda
Employee/Petitioner

v.

Central Grocers
Employer/Respondent

Case # **13** WC **22024**

Consolidated cases: **14 WC 4876**

An *Application for Adjustment 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 **New Lenox**, on **October 5, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **March 6, 2013**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$47,570.66**; the average weekly wage was **$876.35**.

On the date of accident, Petitioner was **46** 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 **$0.00** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$268.00 for payment of medical bills** or other benefits, for a total credit of **$268.00**.

Respondent is entitled to a credit of **$162.00** under Section 8(j) of the Act.

ORDER

Because the petitioner failed to meet his burden to prove an accident that arose out of his employment as well causation, his requests for payment of medical bills, temporary total disability, and permanent partial disability 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

10/16/15
Date

OCT 21 2015

17IWCC0038

FINDINGS OF FACT

Petitioner filed two claims that have been consolidated: 13 WC 22024 for an alleged date of accident of March 6, 2013; and 14 WC 4876 for an alleged date of accident of February 27, 2013. This decision is for the claim filed under 13 WC 22024, in which Petitioner is alleging injuries to both feet due to repetitive trauma. The issues in dispute in that case are: 1) accident, 2) causation, 3) medical expenses, 4) TTD, and 5) nature and extent.

Petitioner testified that he began working for the Respondent approximately six years prior to his alleged accident date. Over these six years, the Petitioner described performing a number of different job duties and titles ranging from being an "order picker" to a "forklift driver." He alleged that he has worked in similar jobs for the past 27 years. At the time of his alleged injury, the Petitioner was driving what he called a "jeep". This jeep was similar to a standup forklift. He would stand on the forklift for approximately two hours at a time and then would receive a customary 15 minute break. He would also receive longer breaks for a meal. The Petitioner alleged that he typically worked either five shifts a week at eight hours a shift or four shifts a week at ten hours a shift and that he spends all day on his feet.

Petitioner testified that as part of his employment with Respondent, he is required to wear steel toe boots. Respondent would allow a boot vendor to come into the facility to provide boots for the employees – all of which were paid for by the Respondent. The Petitioner testified that he had five to seven boot styles from which to choose. The employees would try on the different boots, select the style and size they liked best, and the Respondent would order the boots chosen by the employees. The Petitioner testified that he was not required to select a boot from the Respondent's selection of boots. Instead, the Petitioner testified that he could go to a store of his choosing and select any boot he wanted, as long as it was within the posted safety requirement of a steel-toed boot. If the Petitioner had purchased his boots elsewhere, he could submit his receipt to the Respondent and would be reimbursed for his out-of-pocket costs.

Petitioner testified that prior to 2013, he would use Iron Age insulated boots that were normally worn when working in cold storage. When Petitioner went to get new boots some time in 2013, Petitioner was not allowed to select the Iron Age boots by the vendor, and instead chose Wolverine steel toe boots, that did not have any insulation. Soon thereafter, Petitioner began noticing his feet were sore, tender and burning. Petitioner testified that he began limping after using these boots. Petitioner resorted to wearing gym shoes on certain days because his Wolverine boots were uncomfortable. Because the use of gym shoes at the Respondent's work place was in violation of the steel toe boot requirement, Petitioner's supervisor had a discussion with Petitioner. Petitioner told his supervisor about his discomfort with the Wolverine boots and the supervisor provided him with cushioned inserts for his boots. Petitioner testified that the inserts made the Wolverine boots fit tighter and caused him to limp even more.

On March 5, 2013, Petitioner did not report to work because of a snow storm. On March 6, 2013, Petitioner woke up with swollen feet. Because he had difficulty walking, he went to Rochelle Community Hospital where he was subsequently diagnosed with plantar fasciitis, given crutches and taken off work. Records from that medical provider show that the Petitioner had tripped two weeks prior at work. They also indicate the Petitioner was breaking in a new pair of boots and that his complaints of pain were in his right foot.

On March 8, 2013, the Petitioner presented to Dr. Liakos at Midwest Orthopedic Institute stating that he had an accident. (Px. #3). He alleged that the onset of pain was February 27 or February 28. He was complaining of

17IWCC0038

right foot pain. According to the note from Dr. Liakos that same date, the Petitioner alleged a fall either on February 27 or February 28. He reported to the doctor that fell over a pallet and suffered some sort of twisting injury to his right foot. (Px. #3).

The Petitioner continued to treat at Midwest Orthopedic Institute with Dr. Liakos. (Px. #3). The Petitioner continued to complain of pain in both feet. Throughout his treatment with Dr. Liakos, the records note a fall at work as well and at no point mention a pallet being dropped on the Petitioner's foot, as the Petitioner testified. Initially, the doctor stated that he could not explain why the Petitioner was having difficulty weight-bearing since he was already six weeks out from the alleged injury. The doctor specifically noted that most patients with plantar fasciitis were weight bearing at this point and were able to tolerate work. Therefore, the doctor ordered an MRI of the right ankle.

The Petitioner presented to Midwest Orthopedic Institute on April 23, 2013 for an MRI of his right ankle. (Px. #3). This MRI a muscle strain and edema, but no tears or fractures were seen. Another MRI was ordered so the doctor could see the rest of the Petitioner's right foot. Again, this MRI revealed only a muscle strain. (Px. #3). No fractures were seen to support the suspicion of an avulsion fracture as diagnosed in the ER and by Dr. Liakos.

After returning to Dr. Liakos following the MRIs, the petitioner was prescribed physical therapy due to his continued complaints. (Px. #3). The doctor also recommended the Petitioner obtain a larger size boot to see if that would relieve his symptoms. Ultimately, when the Petitioner returned on August 6, 2013 to Dr. Liakos, it was recommended that the Petitioner finish his physical therapy and return to work the following week. (Px. #4). The last time the Petitioner was seen by Dr. Liakos was August 26, 2013, when the Petitioner was advised to continue working full duty.

On December 20, 2013, Dr. Liakos prepared a letter at the request of the Petitioner. (Px. #4). The doctor stated that he did not believe that the Petitioner's fall from February 27 or February 28 was likely the cause of his condition and was not caused, aggravated, or accelerated due to his boots. Again, the doctor noted that the Petitioner fell at work. This letter did not mention at any point a pallet falling on the Petitioner's right foot. The doctor noted the Petitioner's pain was fairly symmetric, but slightly more on the right. He also noted the Petitioner showed some inflammation and edema on the center aspect of the muscles on the MRI which could be related to pressure and shoe wear. The doctor felt that the Petitioner's ill-fitting boots could have contributed to this pain and noted that the Petitioner had significant improvement after he switched to other boots and utilize orthotics.

The Petitioner also requested a report from Dr. Jeffrey Coe at Occupational Medicine Associates of Chicago. (Px. #5). Dr. Coe reviewed the Petitioner's records and evaluated the Petitioner for the purposes of an impairment rating. In his history and summary, the doctor noted the Petitioner suffered a twisting injury to his right ankle after a trip at work while working for the Respondent on February 27, 2013. The doctor felt that there was a causal relationship between both injuries suffered by the Petitioner and his work duties for the Respondent. He felt that injuries did cause permanent disability to both feet and that the Petitioner had reached maximum medical improvement. The doctor calculated the Petitioner's impairment by using the AMA Guides to the Evaluation of Permanent Impairment, Sixth Edition. The diagnosis was bilateral plantar fasciitis with residual symptoms. The doctor felt that the final right foot impairment rating was 2 percent and the final left foot impairment rating was 1 percent.

The Respondent obtained a Section 12 Independent Medical Evaluation report from Dr. Simon Lee dated April

17IWCC0038

9, 2015. Dr. Lee examined the Petitioner. The Petitioner told Dr. Lee that his symptoms essentially began on March 6, 2013. Although, the Petitioner noted that his symptoms began prior to that date when he obtained a new pair of work boots. The Petitioner told Dr. Lee that he was not able to return to work until he was able to obtain a new pair of work boots in a larger size as well as receive orthotics. The Petitioner was still complaining of residual symptoms at this appointment, which was approximately two years after the alleged date of injury. Dr. Lee diagnosed the Petitioner with right foot and heel pain. In his opinion, Dr. Lee found no causal relationship of any alleged work injury to the condition originating or causing the Petitioner's symptoms or complaints. Dr. Lee stated there was no evidence based on the Petitioner's statements that there was any specific trauma to his foot. Dr. Lee opined that there was no repetitive injury. The doctor noted that the Petitioner had complaints of ill-fitting shoe wear, however, he found no reason why the Petitioner did not report this ill-fitting shoe wear issue immediately rather than attempt to continue to wear the shoes on a prolonged basis. Dr. Lee also took issue with the fact that the original documentation and report appeared to indicate right-sided symptoms and complaints, but at the evaluation, the Petitioner was complaining of diffuse and relatively atypical bilateral lower extremity symptoms and complaints that would not be substantiated by any work related injury or the original injury to the right lower extremity. The doctor also did not feel that plantar fasciitis was an accurate diagnosis. The Petitioner's symptoms showed some tenderness over the medial plantar fascia region but that the Petitioner had more diffuse pain in all other areas that were also symmetric and did not have discrete anatomical diagnoses or basis. The doctor opined that the Petitioner had some diffuse and non-specific edema with the plantar musculature and subcortical bone but there was no evidence substantiating the cause of these symptoms. The doctor agreed that the Petitioner was at maximum medical improvement and that he could continue working his full and previous work duties with no restrictions.

Respondent presented a recorded statement from the Petitioner taken on March 8, 2013, the same date as his first visit with Dr. Liakos, and the same day he filled out the above-referenced intake form Dr. Liakos. (Rx. #5). In this recorded statement, the Petitioner told the claims adjuster at Sentry Insurance that he had fallen somewhere between February 17 and February 26. This recorded statement makes no mention of a pallet hitting or being dropped on his foot on February 27 or February 28. Furthermore, at the end of this recorded statement, the Petitioner stated that he felt that he had definitely gotten hurt at work, but did not know exactly when the injury had happened.

Petitioner testified that as a result of his injury, he notes that "he's not me anymore." He hurts everyday with limping, stiffness, burning and pain. He no longer works out like before and has to take care of his mother's 5 acre property, including cutting down trees and cutting the grass.

CONCLUSIONS OF LAW

1. With regard to the issue of accident, the Arbitrator finds that the Petitioner failed to meet his burden of proof. In support of this finding, the Arbitrator relies on the Petitioner's testimony and the medical evidence. Petitioner is alleging a repetitive trauma accident, but there was insufficient evidence of repetitive work activity to substantiate a repetitive trauma claim. In reviewing the Petitioner's testimony and the medical evidence, essentially, the Petitioner is claiming that wearing uncomfortable boots rose to the level of an accident. However, the records indicate the Petitioner could have chosen different boots or bought his boots on his own for which he would be reimbursed by Respondent. Instead, Petitioner chose to continue wearing the uncomfortable boots to the point his feet began to hurt more. Petitioner first testified that he wore a different brand of steel toe boots that were insulated and comfortable. Although the boot vendor did not provide this model of boot for Petitioner in 2013, there is nothing in the evidence that indicates Petitioner could have either

continued wearing his old boots or else purchase another pair of the more comfortable boots at the Respondent's expense. In light of these facts, the Arbitrator concludes that Petitioner failed to prove he sustained an accident on March 6, 2013.

2. Based on the Arbitrator's findings with regard to the issue of accident, all other issues are rendered moot.

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

Anthony Molenda,
Petitioner,

vs.

NO: 14WC4876

Central Grocers,
Respondent,

17IWCC0039

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 21, 2015, is hereby affirmed and adopted.

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

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

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

DATED: JAN 24 2017
o011817
CJD/jrc
049

Charles J. DeVriendt

Joshua D. Luskin

Ruth W. White

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MOLENDA, ANTHONY
Employee/Petitioner

Case# **14WC004876**

13WC022024

CENTRAL GROCERS
Employer/Respondent

17IWCC0039

On 10/21/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.11% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0293 KATZ FRIEDMAN EAGLE ET AL
DAVID M BARISH
77 W WASHINGTON ST 20TH FL
CHICAGO, IL 60602

3998 ROSARIO CIBELLA LTD
BENJAMIN BRESLAU
116 N CHICAGO ST SUITE 600
JOLIET, IL 60432

STATE OF ILLINOIS)
)SS.
COUNTY OF WILL)

17IWCC0039

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Anthony Molenda
Employee/Petitioner

v.

Central Grocers
Employer/Respondent

Case # **14** WC **4876**

Consolidated cases: **13 WC 22024**

An *Application for Adjustment 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 **New Lenox**, on **October 5, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **February 27, 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 **$45,570.66**; the average weekly wage was **$876.35**.

On the date of accident, Petitioner was **46** 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 **$0.00** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$268.00 for payment of medical bills** or other benefits, for a total credit of **$268.00**.

Respondent is entitled to a credit of **$162.00** under Section 8(j) of the Act.

ORDER

Petitioner failed to meet his burden of proof on the issue of accident. 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

10/16/15
Date

OCT 2 1 2015

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FINDINGS OF FACT

Petitioner filed two claims that have been consolidated: 13 WC 22024 for an alleged date of accident of March 6, 2013; and 14 WC 4876 for an alleged date of accident of February 27, 2013. This decision is for the claim filed under 14 WC 4876, in which Petitioner is alleging injury to his right foot due to a direct trauma. The issues in dispute in this case are: 1) accident, 2) causation, 3) medical expenses, 4) TTD, and 5) nature and extent.

Petitioner testified that he began working for the Respondent approximately six years prior to his alleged injury on February 27, 2013. Over these six years, the Petitioner described a number of different job duties and titles ranging from being an "order picker" to a "forklift driver." He alleged that he has worked in similar jobs for the past 27 years. At the time of his alleged injury, the Petitioner was working, driving what he called a "jeep". This jeep was similar to a standup forklift. He would stand on the forklift for approximately two hours at a time and then would receive a customary 15 minute break. He would also receive longer breaks for a meal. The Petitioner alleged that he typically worked either five shifts a week at eight hours a shift or four shifts a week at ten hours a shift.

The Petitioner alleged that on the date of injury he started his shift at approximately 7:30 p.m. on February 27, 2013 and ended his shift at approximately 4:00 a.m. on February 28, 2013. The Petitioner testified that at some time during this shift, thousands of cans of corn were spilled by a fellow employee. The Petitioner testified that he was told by his supervisor to help clean up this spill. While doing so, the Petitioner testified that another employee dropped a pallet on his right foot and ankle, causing injury.

The Petitioner testified that he continued to work three more shifts before seeking medical attention. Despite this alleged injury, the Petitioner was able to perform all of his job duties during those three shifts. The Petitioner testified that he was already experiencing some soreness in his right foot due to having received new boots from the Respondent. These boots were issued approximately one month prior to the alleged date of injury (Px. #1) and is they are the subject of Petitioner's companion case 13 WC 22024.

The Petitioner first sought medical treatment on March 6, 2013 at Rochelle Community Hospital. (Px. #2) He presented to the emergency room complaining of right foot pain for "a couple of weeks." The Petitioner complained that the pain was mostly located in the sole of his foot. He stated that he had been breaking in a new pair of boots at work. The record notes that the Petitioner specifically denied any recent trauma, but noted tripping at work approximately two weeks prior to this encounter. X rays were taken and were inconclusive, but an avulsion fracture was suspected. The final diagnosis at this emergency room was plantar fasciitis and a possible mid-foot fracture.

On March 8, 2013, the Petitioner presented to Dr. Liakos at Midwest Orthopedic Institute stating that he had an accident. (Px. #3). He alleged that the onset of pain was February 27 or February 28. He was complaining of right foot pain. According to the note from Dr. Liakos that same date, the Petitioner alleged a fall either on February 27 or February 28. He reported to the doctor that fell over a pallet and suffered some sort of twisting injury to his right foot. A similar history is indicated on the intake form completed and signed by the petitioner on that same date stating that he fell at work and that his boots were also making his feet hurt. (Px. #3).

The Petitioner continued to treat at Midwest Orthopedic Institute with Dr. Liakos. (Px. #3). The Petitioner continued to complain of pain in both feet. Throughout his treatment with Dr. Liakos, the records note a fall at work as well. The records do not mention a pallet striking the Petitioner's foot. Initially, the doctor stated that

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he could not explain why the Petitioner was having difficulty weight-bearing since he was already six weeks out from the alleged injury. The doctor specifically noted that most patients with plantar fasciitis were weight bearing at this point and were able to tolerate work. Therefore, the doctor ordered an MRI of the right ankle.

The Petitioner presented to Midwest Orthopedic Institute on April 23, 2013 for an MRI of his right ankle. (Px. #3). This MRI a muscle strain and edema, but no tears or fractures were seen. Another MRI was ordered so the doctor could see the rest of the Petitioner's right foot. Again, this MRI revealed only a muscle strain. (Px. #3). No fractures were seen to support the suspicion of an avulsion fracture as diagnosed in the ER and by Dr. Liakos.

After returning to Dr. Liakos following the MRIs, the petitioner was prescribed physical therapy due to his continued complaints. (Px. #3). The doctor also recommended the Petitioner obtain a larger size boot to see if that would relieve his symptoms. Ultimately, when the Petitioner returned on August 6, 2013 to Dr. Liakos, it was recommended that the Petitioner finish his physical therapy and return to work the following week. (Px. #4). The last time the Petitioner was seen by Dr. Liakos was August 26, 2013, when the Petitioner was advised to continue working full duty.

On December 20, 2013, Dr. Liakos prepared a letter at the request of the Petitioner. (Px. #4). The doctor stated that he did not believe that the Petitioner's fall from February 27 or February 28 was likely the cause of his bilateral foot condition and was not caused, aggravated, or accelerated due to his boots. Again, the doctor noted that the Petitioner fell at work. This letter did not mention at any point a pallet striking the Petitioner's right foot. The doctor noted the Petitioner's pain was fairly symmetric, but slightly more on the right. He also noted the Petitioner showed some inflammation and edema on the center aspect of the muscles on the MRI which could be related to pressure and shoe wear. The doctor felt that the Petitioner's ill-fitting boots could have contributed to this pain and noted that the Petitioner had significant improvement after he switched to other boots and utilize orthotics. There was no mention as to where the orthotics came from, but there is no indication that they were custom, prescribed orthotics.

The Petitioner also requested a report from Dr. Jeffrey Coe at Occupational Medicine Associates of Chicago. (Px. #5). Dr. Coe reviewed the Petitioner's records and evaluated the Petitioner for the purposes of an impairment rating. In his history and summary, the doctor noted the Petitioner suffered a twisting injury to his right ankle after a trip at work while working for the Respondent on February 27, 2013. The doctor felt that there was a causal relationship between both injuries suffered by the Petitioner and his work duties for the Respondent. He felt that injuries did cause permanent disability to both feet and that the Petitioner had reached maximum medical improvement. The doctor calculated the Petitioner's impairment by using the AMA Guides to the Evaluation of Permanent Impairment, Sixth Edition. The diagnosis was bilateral plantar fasciitis with residual symptoms. The doctor felt that the final right foot impairment rating was 2 percent and the final left foot impairment rating was 1 percent.

The Respondent obtained a Section 12 Independent Medical Evaluation report from Dr. Simon Lee dated April 9, 2015. Dr. Lee examined the Petitioner. The Petitioner told Dr. Lee that his symptoms essentially began on March 6, 2013. Although, the Petitioner noted that his symptoms began prior to that date when he obtained a new pair of work boots. The Petitioner told Dr. Lee that he was not able to return to work until he was able to obtain a new pair of work boots in a larger size as well as receive orthotics. The Petitioner was still complaining of residual symptoms at this appointment, which was approximately two years after the alleged date of injury. Dr. Lee diagnosed the Petitioner with right foot and heel pain. In his opinion, Dr. Lee found no causal relationship of any alleged work injury to the condition originating or causing the Petitioner's symptoms

17IWCC0039

or complaints. Dr. Lee stated there was no evidence based on the Petitioner's statements that there was any specific trauma to his foot. Dr. Lee opined that there was no repetitive injury. The doctor noted that the Petitioner had complaints of ill-fitting shoe wear, however, he found no reason why the Petitioner did not report this ill-fitting shoe wear issue immediately rather than attempt to continue to wear the shoes on a prolonged basis. Dr. Lee also took issue with the fact that the original documentation and report appeared to indicate right-sided symptoms and complaints, but at the evaluation, the Petitioner was complaining of diffuse and relatively atypical bilateral lower extremity symptoms and complaints that would not be substantiated by any work related injury or the original injury to the right lower extremity. The doctor also did not feel that plantar fasciitis was an accurate diagnosis. The Petitioner's symptoms showed some tenderness over the medial plantar fascia region but that the Petitioner had more diffuse pain in all other areas that were also symmetric and did not have discrete anatomical diagnoses or basis. The doctor opined that the Petitioner had some diffuse and non-specific edema with the plantar musculature and subcortical bone but there was no evidence substantiating the cause of these symptoms. The doctor agreed that the Petitioner was at maximum medical improvement and that he could continue working his full and previous work duties with no restrictions.

The Petitioner testified that on February 27th or 28th, he did not fall, but rather had a pallet hit him on his right foot and ankle. Petitioner stated that there was a fall at some other point prior to the alleged date of injury, however, at trial he testified on a number of occasions that he suffered no injury to his ankle from any fall at work. , The Respondent presented a recorded statement from the Petitioner taken on March 8, 2013, the same date as his first visit with Dr. Liakos, and the same day he filled out the above-referenced intake form Dr. Liakos. (Rx. #5). In this recorded statement, the Petitioner told the claims adjuster at Sentry Insurance that he had fallen somewhere between February 17 and February 26. This recorded statement makes no mention of a pallet hitting or being dropped on his foot on February 27 or February 28. Furthermore, at the end of this recorded statement, the Petitioner stated that he felt that he had definitely gotten hurt at work, but did not know exactly when the injury had happened.

The parties stipulated to the admissibility of two documents relating to Section 8(e)(17) prior award credits. The first was an Illinois Workers' Compensation Commission database printout from Case # 88WC12841. (Rx. # 2). In this case, which related to an accident date of January 31, 1988 while Petitioner was employed at Dominicks Finer Foods Inc., the Petitioner received a settlement of 2.5 percent loss of use of the right foot. Further, an Illinois Workers' Compensation Commission database printout was presented for Case # 93 WC 45285. (Rx. #3). In this case, which related to an accident date of May 17, 1993 while Petitioner was employed at Certified Grocers, the Petitioner received a settlement Award of 20 percent loss of use of the left foot.

In cross-examination, the Petitioner was confronted with this prior inconsistent statement. In the recorded statement referenced above, the Petitioner told the claims adjuster that he had only one prior workers' compensation injury. (Rx. #5). The Petitioner on cross examination admitted that this was not true and that he in fact had not one but five workers' compensation cases. The Petitioner was able to recall these prior cases, some of them in specific details.

CONCLUSIONS OF LAW

1. With regard to the issue of accident, the Arbitrator finds that the Petitioner failed to meet his burden of proof. In support of this finding, the Arbitrator relies on the Petitioner's testimony and the medical evidence. In particular, the Arbitrator notes that the Petitioner's testimony regarding his accident from February 27, 2013 is not supported by the medical evidence. He testified that a pallet struck his right ankle after a co-workers spilled 1000's of cans of product. The medical records indicate the Petitioner providing a history of tripping, falling or

17IWCC0039

twisting. There is no mention of the Petitioner's leg being struck by a pallet in the medical records. There is also a lack of consistency in the evidence as to when this alleged accident occurred. Given the conflicting and inconsistent evidence, the Arbitrator concludes that the Petitioner's claim lacks credibility and therefore fails to establish that he sustained an accident on February 27, 2013.

2. Based on the Arbitrator's findings with regard to the issue of accident, 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

LeRoy Casey,

Petitioner,

vs.

NO: 14WC 20800

Central Rodding Total Sewer,

17IWCC0040

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 medical, causation, prospective medical, accident, 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 October 15, 2015, is hereby affirmed and adopted.

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $46,300.00. 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 24 2017
o011817
CJD/jrc
049

Charles J. DeVriendt

Joshua D. Luskin

Ruth W. White

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

CASEY, LEROY
Employee/Petitioner

Case# **14WC020800**

CENTRAL RODDING TOTAL SEWER
Employer/Respondent

17IWCC0040

On 10/15/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

2208 CAPRON & AVGERINOS PC
STEVE SMALLING
55 W MONROE ST SUITE 900
CHICAGO, IL 60603

1408 HEYL ROYSTER VOELKER & ALLEN
LYNSEY A WELCH
120 W STATE ST PO BOX 1288
ROCKFORD, IL 61105

17IWCC0040

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)

Leroy Casey
Employee/Petitioner

v.

Central Rodding Total Sewer
Employer/Respondent

Case # 14 WC 20800

Consolidated cases: D/N/A

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Molly Mason**, Arbitrator of the Commission, in the city of **Chicago**, on **9/28/2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **April 9, 2014**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

For the reasons set forth in the attached decision, the Arbitrator finds that Petitioner established causation as to shoulder/brachial plexus, bicipital tendonitis, cervical and lumbar spine conditions of ill-being but failed to establish causation/aggravation as to a pre-existing and progressive neurological disorder and as to carpal tunnel syndrome.

In the year preceding the injury, Petitioner earned **$46,966.92**; the average weekly wage was **$903.21**.

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

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

Respondent shall be given a credit of **$26,192.25** for TTD, $ for TPD, $ for maintenance, and $ for other benefits, for a total credit of **$26,192.25.**.

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

ORDER

- Respondent shall pay the following medical expenses: 1) Franciscan Physician Network (Dr. Carlson), to the extent of the $3,018.63 in payments made by Respondent (RX 1); 2) Mea-Munster, LLC, $501.00, subject to the fee schedule and with Respondent receiving credit for the $450.90 payment it made (RX 1); 3) Imaging Associates of Indiana, $84.00, subject to the fee schedule and with Respondent receiving credit for the $80.33 payment it made (RX 1); 4) Munster Radiology Group, $77.00, subject to the fee schedule; 5) Dr. Julian Ungar-Sargon, $13,094.01, subject to the fee schedule; 6) CVS Pharmacy, prescription reimbursement, $91.99; 7) Merrillville Plaza Surgery, 4/1/15 charges only, $7,755.70, subject to the fee schedule; 8) Franciscan St. Anthony Hospital, $888.00, subject to the fee schedule and with Respondent receiving credit for the $692.64 payment it made (RX 1); and 9) William Mason, M.D., 4/22/15 CT scans, $478.00, subject to the fee schedule. All other claimed medical is denied, for the reasons set forth in the attached decision.

- Respondent shall pay Petitioner temporary total disability benefits of $602.14 per week for 76 5/7 weeks commencing April 10, 2014 through September 28, 2015 as proved in Section 8(b) of the Act, with Respondent receiving credit for the $26,192.25 in benefits it paid prior to the hearing.

- Respondent shall pay Petitioner temporary total disability benefits that have accrued from April 10, 2014 through September 28, 2015 and shall pay the remainder of the award, if any, in weekly payments.

- Respondent is not liable for the prospective care sought by Petitioner, i.e., ongoing treatment by Drs. Carlson and Ungar-Sargon. Respondent shall authorize and pay for prospective care in the form of an evaluation and possible treatment by a board certified physician specializing in brachial plexus injuries.

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

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

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

Molly C Mason
Signature of Arbitrator

10/15/15
Date

OCT 15 2015

Leroy Casey v. Central Rodding Total Sewer
14 WC 20800

Arbitrator's Findings of Fact

Petitioner testified he is currently 58 years old. He finished high school in 1976 and began working in the plumbing trade thereafter. He began working for Respondent about 15 or 16 years before his disputed accident of April 9, 2014.

Petitioner testified his duties for Respondent varied from day to day. He might be assigned to a residential plumbing job one day and be out in the field the next. He worked on manholes and sewer lines and regularly performed lifting. He operated backhoes and different kinds of trucks.

Petitioner acknowledged undergoing a cervical spine fusion at C6-C7 in 1996. Once he recovered from this surgery, he resumed working full duty.

Petitioner testified he was not subject to any limitations or under the care of any doctor before the accident. Petitioner specifically denied having any tremors in his right hand as of the accident. Before the accident, no one diagnosed him with Parkinson's or any other neurological disorder.

Petitioner's medical records reflect he did in fact seek treatment for various conditions, including a right hand problem, in 2013. Electronic record entries in PX 4 show that Petitioner saw Dr. Carlson or another physician in his group on May 15, 2013 for back pain, psoriasis and "arthritis all over his body," on August 13, 2013 for chest pain and right hand weakness and on August 22, 2013 for a CDL examination and GERD. Complete records from these three dates are not in evidence.

Respondent offered into evidence a "wage calculation report" reflecting Petitioner's weekly hours and earnings between April and December 2013. A handwritten statement on this report reflects both that Petitioner "did not work in 2014" and that Petitioner "came back [in 2014] and worked 10.5 hours." RX 6. Petitioner did not object to RX 6. Under cross-examination, Petitioner acknowledged he was off work, collecting unemployment benefits, between January and March 2014. It is not clear whether the claimed accident of April 9, 2014 occurred on Petitioner's first day back to work for Respondent.

Petitioner testified that immediately before the April 9, 2014 accident, he and "Billy," a fellow employee, were working in Country Club Hills, cleaning a manhole. They were using a 4-inch hose and a "vacuum truck" to accomplish this. The hose was attached to a vacuum apparatus on the back of a truck. Petitioner was working next to the manhole while Billy was next to the truck. Petitioner testified he was crouching down, holding the hose in both hands, when Billy "flipped an arm" on the truck. This caused the hose to jerk violently. Petitioner testified that, when the hose jerked, he felt his head suddenly move backward, as if it was going

to come into contact with his back. His knees hit the ground and he almost went down into the manhole.

Petitioner testified he noticed a tremor in his right hand immediately after the accident. He told Billy he did not feel good.

Petitioner testified that, when he woke up the morning after the accident, he was still experiencing the tremor. He was also experiencing neck and back pain. He reported to work and told Respondent's owner's wife about the accident. He also indicated he needed to see a doctor. [Notice is not in dispute. Arb Exh 1.]

Petitioner testified he went to the Emergency Room following the accident. No Emergency Room records are in evidence but a check in RX 1 reflects Petitioner went to Community Hospital in Munster on April 10, 2014. Petitioner's failure to offer the Emergency Room records is puzzling. A summary of the Emergency Room care appears in the report of Dr. Ross, Respondent's first Section 12 examiner. Dr. Ross indicated Petitioner complained of right shoulder, scapular and wrist pain as well as a slight tremor in his right hand secondary to the work accident. He also indicated Petitioner was given Ibuprofen, Flexeril and Tramadol and was directed to seek follow-up care. PX 2.

Petitioner testified he followed up with Dr. Carlson after being discharged from the Emergency Room. He described Dr. Carlson as a "new" primary care physician he had not previously seen but, as noted above, records in PX 4 reflect he saw Dr. Carlson in 2013.

On April 11, 2014, Dr. Carlson noted Petitioner had been injured at work the previous day and had undergone X-rays at Community Hospital. He also noted that Petitioner had been given prescriptions for Flexeril, Motrin and Tramadol and complained of being unable to sleep due to right shoulder and arm numbness. He further noted a tremor in Petitioner's right hand and a complaint of back and neck pain. He indicated that no X-rays of the back or neck were performed at the hospital. He ordered cervical and lumbar spine X-rays. The cervical spine X-rays showed changes consistent with the previous fusion, mild cervical spondylosis at C5-C6 and moderate facet arthropathy from C4-C5 through C7-T1. The lumbar spine X-rays showed severe degenerative disc disease. PX 4.

Petitioner returned to Dr. Carlson on April 18, 2014. The doctor noted a complaint of back pain radiating through the left buttock as well as pain in the neck, right shoulder and right wrist. He again noted the right arm tremor, which he described as worsening. He indicated that Petitioner denied having this tremor before the work accident. On examination, he noted paravertebral spasm bilaterally in the back, a decreased range of motion in the right shoulder and swelling in the right wrist. He prescribed cervical and lumbar spine MRI scans, along with orthopedic and neurological consultations. PX 4.

On May 2, 2014, Dr. Carlson noted that Petitioner's shoulder was slightly better but that he was still experiencing low back pain radiating to his buttocks, hand tremors and numbness in

his hands and arms at night. He discontinued the Flexeril and indicated he was still waiting for workers' compensation to authorize the MRIs. PX 4.

On May 5, 2014, Dr. Carlson noted that Petitioner reported "increased pain over the weekend in right neck, arm and lower back." He also noted that increasing Petitioner's Ultram dosage "didn't help decrease pain." He prescribed Norco. PX 4.

On May 12, 2014, Dr. Carlson noted that Petitioner rated his pain at "8/10 all the time" and complained of "shaking to right arm at all times, like tremor." On examination, he noted limited motion and 2/5 strength in the right arm and a full range of motion in the other extremities. The following day, Petitioner called the doctor's office and requested a note indicating he needed to remain off work. PX 4.

On May 19, 2014, Dr. Carlson noted that Petitioner reported taking two Norco 5 mg tablets at one time to obtain pain relief. On examination, the doctor noted a tremor in Petitioner's left upper extremity. [It is not clear whether this is an error]. PX 4.

On May 20, 2014, workers' compensation authorized the MRI scans. On May 23, 2014, Petitioner contacted Dr. Carlson's office and indicated he had been unable to complete the MRIs due to claustrophobia. Dr. Carlson prescribed Valium on May 27, 2014. PX 4.

Petitioner was able to complete the MRI scans on May 28, 2014. The cervical spine MRI showed evidence of the previous fusion, a broad-based bulging disc at C5-C6 and spurring of the uncinated processes and bulging disc resulting in foraminal narrowing bilaterally, greater on the left. The lumbar spine MRI showed extensive multi-level degenerative disc disease, mild central canal stenosis from L2-L3 through L4-L5 and asymmetric foraminal stenosis at L3-L4 on the right secondary to a right foraminal disc protrusion. PX 4.

On June 2, 2014, Petitioner complained to Dr. Carlson of lower back pain radiating down both legs, as well as persistent tremors and neck and shoulder pain. On examination, the doctor noted a right upper extremity tremor. He refilled Petitioner's medication and recommended a neurological consultation. PX 4.

Dr. Carlson continued noting similar complaints thereafter. On June 9, 2014, he noted that Petitioner was pain and tremor free prior to the work accident. On June 30, 2014, he noted Petitioner was scheduled to see a neurologist. PX 4.

At Respondent's request, Petitioner saw Dr. Ross, a neurosurgeon, for purposes of a Section 12 examination on July 3, 2014. The doctor's report of that date sets forth a history of the prior C6-C7 fusion and the April 9, 2014 work accident. The doctor indicated that Petitioner reported being "yanked forward" at the time of the accident. He also indicated that Petitioner reported experiencing bilateral hand numbness when he tried to sleep the night of the accident and new trembling or shaking in his right hand. He indicated that Petitioner "denies ever having had tremor in the past."

On examination, Dr. Ross noted a "pronounced high frequency tremor in the right hand and forearm." He indicated that the tremor would "quiet" at times and become more pronounced at other times. He specifically noted that the tremor subsided when Petitioner "concentrates on rapid finger tapping on the left hand." He described Petitioner's gait as normal. He noted a full range of cervical and lumbar spine motion, slight weakness in all the muscle groups of the right arm and hand, full strength in the left arm and both legs, pinprick "perceived as being reduced over the thumb, index, ring and little fingers of the right hand" and slightly weak but symmetric deep tendon reflexes.

Dr. Ross indicated he reviewed a CD containing images of the May 28, 2014 cervical and lumbar spine MRIs. He interpreted the cervical spine MRI as showing a well healed C6-C7 fusion and some early degenerative changes developing at C5-C6, above the fused level. He interpreted the lumbar spine MRI as showing degenerative changes at multiple levels, "some foraminal disc herniation at L3-L4 on the right side" and "some foraminal narrowing at L4-L5 on the left."

Dr. Ross opined that Petitioner "likely sustained mild cervical, right shoulder and lumbosacral strains as a result of his work injury of April 9, 2014." He described Petitioner's tremor and right arm weakness as "more puzzling." He indicated Petitioner had no cervical spine pathology to explain the diffuse right arm weakness and no indication of a spinal cord injury that would likely cause a tremor. He found it "possible that [Petitioner] sustained a brachial plexus stretch injury," although he "did not find supporting evidence for this diagnosis in [Petitioner's] reflex examination." He indicated that, while a nerve injury could lead to tremor, Petitioner's examination was "certainly suspicious for the movement disorder being nonorganic or psychogenic." With respect to the work injury, he recommended an EMG/NCV of the right arm as well as a formal consultation with a neurology movement disorder specialist. He also found it appropriate for Petitioner to undergo therapy for his right shoulder pain and cervical and lumbar strains. He found Petitioner capable of light duty, with lifting up to 25 pounds. He indicated Petitioner might require work conditioning prior to a full duty release, "given the heavy physical nature of his job." He indicated that work conditioning should not be initiated until after Petitioner underwent the EMG, neurology consultation and three to four weeks of therapy. He stated that, "in a best case scenario, [Petitioner] would be able to return to full duty work in approximately three months and reach MMI in approximately four months." He indicated these estimates could change depending on the results of additional diagnostic work-up. PX 2.

On August 4, 2014, Dr. Carlson noted positive straight leg raising bilaterally as well as a persistent right arm tremor. He indicated that Petitioner was scheduled to undergo an EMG the next day. He also indicated that Petitioner remained totally disabled. PX 4.

On September 23, 2014, Dr. Ross issued an addendum indicating he reviewed an EMG report dated August 5, 2014. He described this EMG as showing left carpal tunnel syndrome. He indicated that the examiner might have performed a right-sided nerve conduction study but

that this was not mentioned in the "impression" section of the report. He suspected there were pages missing from the report or that the examiner got confused in his dictation. In either event, he viewed the EMG report as "inadequate." He indicated the EMG might need to be repeated if the examiner was unable to review the raw data and generate a more comprehensive report addressing both arms. He described the left carpal tunnel syndrome as "probably unrelated" to the work accident. He addressed the tremor issue as follows:

> "As mentioned earlier, the evaluation and treatment of a tremor is the province of a movement disorder neurologist. If the tremor is confirmed to be nonorganic or psychogenic, the connection to the work injury would be tenuous and linked via psychologic or psychiatric issues rather than true neurologic pathology."

PX 2.

Petitioner continued seeing Dr. Carlson throughout this period. The doctor started Petitioner on a low dose of Gabapentin and noted this seemed to help the right arm tremor somewhat. On November 25, 2014, the doctor noted Petitioner was having difficulty dorsiflexing his right foot. On December 9, 2014, the doctor described Petitioner's gait as "shuffling." PX 4.

At Respondent's request, Petitioner underwent a Section 12 examination by Dr. Karen Levin on January 5, 2015. Petitioner testified Dr. Levin spent only seven or eight minutes with him on that date. Petitioner indicated he walked down a hall at Dr. Levin's direction, with the doctor observing him.

In her report, Dr. Levin noted that Petitioner's wife accompanied him to the examination. She indicated that Petitioner's wife described Petitioner as a "workaholic working two jobs" before the April 9, 2014 accident.

Dr. Levin recorded a consistent history of the previous cervical fusion, the work accident and the post-accident care. She indicated that Petitioner complained of neck pain, 8/10 daily headaches, arm numbness, a tremor and pain in his right arm, right leg numbness and a right foot drop. She also indicated that, on further inquiry, Petitioner admitted to difficulty getting out of chairs and Petitioner's wife noted that Petitioner's voice was now "definitely softer," that his handwriting was now "scribbled" and that he now spent his days watching television. According to Dr. Levin, Petitioner related that work sent him for an EMG but that the test had to be stopped because the doctor performing the study told him he had Parkinson's. She indicated that Petitioner denied any familial history of Parkinson's or other neurodegenerative disease.

Dr. Levin described Petitioner as having a "masked face," slightly decreased sensation on the left side of the face, significantly increased tone, with "tremor, rigidity and decreased

rapid movements" and a "significantly stooped posture with a shuffling gait with a very narrow base."

Dr. Levin indicated she reviewed an Employer's First Report of Injury, prepared by Karen Eyler, and a description of Petitioner's job. The Arbitrator notes these documents are not in evidence. Dr. Levin also indicated she reviewed the initial Emergency Room records along with multiple treatment notes and Dr. Ross's reports.

Dr. Levin opined that the work accident resulted in a "minor pull injury to the right arm." She found Petitioner's current examination "completely suggestive of Parkinson's disease." She indicated this disease was not caused or aggravated by a "peripheral pull injury to the arm." She theorized that the work accident "was just an event that made [Petitioner] more aware of the tremor." She described the Parkinson's as Petitioner's "biggest problem at the moment." She described Dr. Carlson's care as "excessive," indicating the work accident did not require weekly follow-up for months. She recommended that Petitioner see a neurologist and start medication for the Parkinson's. She indicated that any work restrictions would be from the Parkinson's and not the work accident. She took the step of contacting Respondent's attorney "so that he could contact [Petitioner's] lawyer and let him that [Petitioner] does need treatment for Parkinson's." She indicated that Petitioner's Parkinson's was not drug-induced, noting that none of the medication Petitioner had been taking would cause Parkinson's.

Dr. Levin opined that Petitioner reached maximum medical improvement from the work accident within several weeks of the accident. She described Petitioner's prognosis from his non-work-related Parkinson's as "very poor." RX 3.

On January 8, 2015, Dr. Carlson issued a note indicating Petitioner remained totally disabled. PX 4.

On March 11, 2015, Petitioner saw Dr. Ungar-Sargon. The doctor's note of that date sets forth a history of the prior C6-C7 surgery and the work accident of April 9, 2014. The doctor noted that Petitioner described his neck as having been "jerked forward" at the time of the accident.

Dr. Ungar-Sargon noted that Petitioner complained of severe neck pain, severe occipital headaches, pain radiating to both shoulders, arms, forearms and hands and low back pain radiating to both buttocks and down both legs, primarily on the left. The doctor also noted that Petitioner complained of "tremor and shaking in the neck, shoulders, arms, wrist and hands" as well as numbness in the right leg and foot, tremors in the right leg "most of the day" and "weakness in all the right side of the body." The doctor indicated that Petitioner reported being unable to work on a computer or perform any household tasks such as washing dishes.

On cervical spine examination, Dr. Ungar-Sargon noted hypertonicity, spasm and tenderness on the right side and tenderness at the manubriosternal joint and paracervical muscles. On right shoulder examination, the doctor noted joint asymmetry, swelling and

"dropped shoulder" as well as limited flexion and positive Hawkins and apprehension testing. On right elbow examination, the doctor noted swelling and tenderness over the lateral epicondyle. On right hand examination, the doctor noted a painful range of motion and tenderness to palpation over the hypothenar eminence. On lumbar spine examination, the doctor noted spasm and positive straight leg raising on the right at 60 degrees. On right hip examination, the doctor noted tenderness over the groin and SI joint as well as 3/5 strength of the upper right proximal muscle.

On sensory examination, the doctor noted a "loss of all modality in the upper extremities" and positive Tinel's on the left. He also documented "involuntary movements such as spasms and spasmodic torticollis."

Dr. Ungar-Sargon diagnosed various conditions, including carpal tunnel syndrome and brachial plexus injury. He recommended an EMG, SSEP testing and a CT scan. He directed Petitioner to return to him in two weeks. PX 1.

Petitioner underwent the EMG the same day. Dr. Ungar-Sargon interpreted the study as showing "acute changes in upper trunk muscles on the right." He indicated his impression was "focal acute right brachial plexopathy." PX 1, p. 8.

On March 12, 2015, Dr. Carlson noted that Petitioner had seen a local neurologist who was not affiliated with workers' compensation. He noted a gait problem but indicated Petitioner's gait was not festinating. He noted a persistent resting tremor in the right arm but no "pill rolling" or lip smacking. PX 4.

Petitioner returned to Dr. Ungar-Sargon on March 20, 2015. The doctor's examination findings were unchanged. He performed another EMG. He interpreted this study as showing "focal denervation in left leg and paraspinals." His impression was "focal left lumbar radiculopathy." He recommended a soft neck collar and a lumbar epidural injection. He prescribed Norco and Flexeril and directed Petitioner to return in two weeks. PX 1, pp. 10-11.

On April 1, 2015, Dr. Ungar-Sargon performed a lumbar spine facet block and medial branch block at the Merrillville Plaza Surgery Center. PX 1, pp. 22-23, 81. PX 3.

On April 6, 2015, Dr. Carlson noted that Petitioner received a lower back injection the previous week "to no avail." He again noted the right arm tremor. He indicated Petitioner remained totally disabled. PX 4.

On April 8, 2015, Dr. Ungar-Sargon noted a new complaint of bilateral wrist pain and numbness and tingling in the right ring and small finger. The doctor discontinued the Flexeril and started Petitioner on Percocet. PX 1, pp. 25-27.

On April 22, 2015, Petitioner underwent a CT scan of the right shoulder. The radiologist interpreted the scan as showing no fracture, dislocation or bone destruction. He indicated the

acromioclavicular joint appeared intact. He saw a "tiny nonspecific calcification at the anterior superior margin of the right acromioclavicular joint" which he indicated might relate to some minimal hydroxyapatite deposition disease.

Petitioner underwent cervical spine and brain CT scans the same day. The radiologist interpreted the cervical spine scan as showing evidence of the prior surgical fusion at C6-C7 and mild degenerative disc disease at C5-C6. He interpreted the brain CT scan as showing mild bilateral posterior ethmoid sinus disease, "likely chronic." PX 1, pp. 33-36.

On April 29, 2015, Dr. Ungar-Sargon noted a complaint of sharp neck pain radiating to the right shoulder, arm, wrist and hand as well as low back pain and primarily left-sided leg pain. The doctor's examination findings were unchanged. He refilled Petitioner's medications. PX 1, pp. 39-40.

On May 6, 2015, Dr. Ungar-Sargon performed a lumbar epidural injection at L4-L5. PX 3.

On June 4, 2015, Dr. Carlson noted that Petitioner was still complaining of pain and tremor but told him that the tremor would decrease to the point where it stopped when he was at home. PX 4.

On June 16, 2015, Dr. Carlson noted that a neurologist retained by workers' compensation had diagnosed Petitioner with Parkinson's. He indicated that his own evaluation "did not support that diagnosis." He noted that at no time in his office did Petitioner exhibit cogwheel rigidity of any extremity or a festinating gait. He again noted a right upper extremity tremor. PX 4.

Dr. Ungar-Sargon performed EEG testing on June 29, 2015. He found no electrophysiological evidence for encephalopathy. PX 1, p. 59.

On July 1, 2015, Dr. Ungar-Sargon noted that Petitioner complained of severe pain in multiple body parts and reported experiencing only two days of relief following the May 2015 injection. The doctor refilled the Norco prescription and prescribed a cervical collar and another lumbar injection. PX 1, pp. 55-57.

Dr. Ungar-Sargon testified by way of evidence deposition on July 8, 2015. PX 6. The doctor testified he attended medical school in England, came to the United States in 1974, did a residency in neurology at Columbia, underwent fellowship training thereafter and went into private practice in Merrillville, Indiana in 1988. PX 6 at 6. He is board certified in pain management and neurodiagnostic medicine and board eligible in neurology and psychiatry. PX 6 at 7. He limits his practice to neurology, which includes disorders of the brain and spine. PX 6 at 7-8. He is affiliated with Jasper County Hospital. PX 6 at 8.

Dr. Ungar-Sargon testified he independently recalls Petitioner. Petitioner remains under his care. PX 6 at 6.

Dr. Ungar-Sargon testified he has never reviewed Dr. Ross's report. He regularly deals with patients who have Parkinson's disease and tremors but he is not a "movement disorder neurologist." Such a neurologist would practice in a university setting and enroll patients in various drug trials. PX 6 at 10.

Dr. Ungar-Sargon testified that he does not believe Petitioner has Parkinson's disease. Parkinson's is a degenerative syndrome that affects the elderly. Specifically, it affects the extremities and results in generalized tremors, gait instability and rigidity in the limbs. Petitioner has some tremors in his right arm but "one symptom does not make a diagnosis." PX 6 at 11. A brain MRI might enable you to diagnose the syndrome in its very late stages but the early stages cannot be diagnosed via an MRI or brain wave test. The diagnosis has to be made clinically. PX 6 at 13. The "last test" you might use to try to diagnose Parkinson's is an EMG so he does not understand why Dr. Ross recommended this. PX 6 at 13.

Dr. Ungar-Sargon testified he first saw Petitioner on March 11, 2015, at which time Petitioner provided a history of the work accident. He performed a nerve conduction study, which showed that Petitioner has carpal tunnel syndrome. This syndrome may be occupation-related but it is not related to the work accident. It is an "incidental finding." PX 6 at 15, 18. The nerve conduction study results would have no bearing on the question of whether Petitioner has Parkinson's. PX 6 at 15.

Dr. Ungar-Sargon opined that the work accident resulted in a brachial plexus injury to the right shoulder, leaving Petitioner with denervation in those muscles. PX 6 at 15.

The following exchange then took place:

"Q: You did, I believe, testify that you observed he had tremors in his right arm.

A: Yeah. Uh-huh.

Q: To what would you attribute those tremors?

A: I don't know.

Q: Is it an involuntary movement of the arm?

A: Yes, it is.

Q: Based upon your expertise and in the course of your practice, are there more likely than not certain causes of that?

A: I mean, there are a number of causes. One is familial. One

> is benign essential tremor that occurs in middle-aged people. He had this tremor before the accident although he does tell me it was made worse by the accident. He kept insisting on that."

PX 6 at 16.

Dr. Ungar-Sargon testified he was very surprised by the amount of nerve damage to the neck and brachial plexus Petitioner sustained. This told him that Petitioner "must have really fallen and really injured that part of his body." PX 6 at 16. Because Petitioner already had surgical hardware in his cervical spine, he was more likely to suffer a severe result from the work accident than a person whose neck was not fused. PX 6 at 17. The CT scan Petitioner underwent after the accident showed a broad-based bulge at C5-C6 which "could have been related to" the work accident. PX 6 at 17-18. He also believed the accident caused bicipital tendonitis, or inflammation in the tendons of the biceps from the stretch injury. PX 6 at 18. Petitioner also complained of low back pain radiating into his left thigh, "which never happened before the injury." PX 6 at 18. Given that Petitioner denied any significant prior issues with his neck or back, it was reasonable for him to assume the accident caused the neck and back problems. PX 6 at 19. Petitioner's neck and back problems are wholly unrelated to possible Parkinson's. PX 6 at 20. The left leg EMG he performed on March 20, 2015 showed acute nerve irritation as well as chronic changes. PX 6 at 20-21. He originally believed Petitioner's radicular complaints came from the L4-L5 level, which is why he performed a medial branch block in April. The block was "quite successful." PX 6 at 22. He felt he did not need to order a lumbar spine MRI because of the dramatic EMG results. PX 6 at 22.

Dr. Ungar-Sargon testified that Petitioner requires a "pretty heavy dosage of narcotics" to control his pain and spasms. To date, Petitioner has undergone one lumbar injection. Petitioner reacted favorably to this injection but recently indicated his pain is back up to 7/10. PX 6 at 24, 26. The doctor testified he has not yet recommended a second injection. Petitioner's brachial plexus stretch injury is much harder to treat. Therapy makes it worse and the "literature is very muddy" as to whether injections or blocks would help. He is therefore just bringing Petitioner along with opiates, rest and splinting. PX 6 at 24, 29. He is trying to keep Petitioner away from surgeons because they would love to remove the cervical disc. He does not think that removal of this disc would be helpful in light of Petitioner's brachial plexus injury. As of Petitioner's last visit, on July 1, 2015, his lumbar prognosis was that Petitioner would continue to improve with injections. In terms of the brachial plexopathy, however, that is a "permanent nerve injury that is unlikely to improve because of the severe denervation shown on the EMG." Petitioner needs 30 milligrams of opium per day "just to keep him functioning." PX 6 at 29.

Dr. Ungar-Sargon testified that Petitioner is currently totally disabled and unable to perform even sedentary duty. PX 6 at 30. Petitioner has to alternate lying down with standing and any activity involving his right hand exacerbates the pain and weakness. PX 6 at 30.

Dr. Ungar-Sargon testified he "absolutely" wants to avoid referring Petitioner to a surgeon. PX 6 at 30.

Under cross-examination, Dr. Ungar-Sargon testified that symptoms of Parkinson's include difficulty with speech, a "masked face," tremors on both sides of the body, rigidity, difficulty getting up out of a chair or bed, a stooped posture, a shuffling gait, poor stability and a change in handwriting. When patients come to his office, they either fill out paperwork on their own or get assistance from a loved one. PX 6 at 32-33.

On redirect, Dr. Ungar-Sargon testified he has not observed the foregoing symptoms in Petitioner. His only explanation for Dr. Levin's finding that Petitioner has Parkinson's is that she may be looking to find an excuse not to reimburse Petitioner for his work injury. He does not see how she could say Petitioner has a "masked face" since she saw Petitioner only once. Petitioner's tremor could cause difficulty with writing but "just because you have tremors does not mean you have Parkinson's." He cannot believe she found cogwheeling, rigidity and tremors in the left arm. Petitioner's tremor is only in his right arm. He has followed Petitioner for four months. Petitioner does not have Parkinson's. PX 6 at 34. The recommended medication for Parkinson's is L-Dopa. It is a heavy duty medication. Injections are not used to treat Parkinson's. PX 6 at 34-35. The fact Petitioner responded positively to the lumbar injection helps confirm that Petitioner is honest. PX 6 at 35. An EMG looks at the peripheral nervous system and Parkinson's is a disorder of the central nervous system. PX 6 at 35-36. The EEG he performed was normal. If Petitioner had Parkinson's, the EEG would not have been normal. PX 6 at 36.

Under re-cross, Dr. Ungar-Sargon testified that Petitioner did not tell him what he is hoping to receive from his claim. Some of his patients embellish, fake and malinger. Such patients would not report improvement from an injection. PX 6 at 37.

Petitioner continued seeing Dr. Carlson throughout this period. On August 11, 2015, the doctor noted that Petitioner was "still taking Percocet for pain in neck, back and throughout body." He noted no change in the right arm tremor. PX 4.

On September 1 and 14, 2015, shortly before the hearing, Dr. Carlson noted ongoing back, neck, arm and wrist pain as well as a right arm tremor. He also noted that Petitioner was seeing a neurologist. He described Petitioner's gait as antalgic but not festinating. PX 4.

On September 2, 2015, Dr. Ungar-Sargon noted ongoing complaints of back pain and administered another lumbar epidural injection. PX 1, pp. 70-72.

Petitioner testified he attempts to control the tremor in his right arm by using his left hand to hold the arm in a fixed position. He experiences the tremor "24/7." The tremor lessens a little when he is relaxed but it never goes away. He cannot use his right hand to write and it bothers him to move his right arm. His neck and arms get numb at night. His low back pain prevents him from sleeping well. He continues to see Drs. Carlson and Ungar-Sargon on a

regular basis. These doctors have kept him off work. At Dr. Ungar-Sargon's direction, he takes Oxycodone twice daily. He is scheduled to return to Dr. Ungar-Sargon on October 3, 2015. He is not sure what treatment is planned for that date. The medical bills in PX 5 relate to his work accident.

Under cross-examination, Petitioner testified he has been honest with his treating physicians. He has no reason to lie to them. He was "on [his] own" before the work accident. He was off work, drawing unemployment benefits, between January and March 2014. It was seven years ago that he was off work for a more substantial period. Following the accident, he first underwent care on April 10, 2014. There were two trucks at the jobsite where the accident occurred. Both trucks had to be driven by CDL-qualified drivers. After the accident, he got in one of these trucks but was not able to use his right hand to shift the gears. He has undergone two EMGs. He does not recall the first EMG being stopped. He is not aware that his records state he complained of left-sided tremors. He has no real difficulty with his speech, except when he is nervous. He has difficulty getting up out of a chair. He has to change positions frequently.

On redirect, Petitioner testified he underwent the first EMG after being examined by Dr. Ross. He later underwent a second EMG.

No witnesses testified on behalf of Respondent.

In addition to the exhibits previously summarized, Respondent offered into evidence a print-out of the benefits it has paid to date in connection with Petitioner's claim. This print-out reflects that Respondent paid temporary total disability benefits from April 10, 2014 through January 21, 2015 along with an advance of $2,113.36 and various medical expenses. RX 1.

Arbitrator's Credibility Assessment

Petitioner's testimony concerning the claimed work accident was detailed, believable and unrebutted. Petitioner lacked credibility, however, as to his pre-accident state of health and treatment.

Petitioner's testimony concerning the onset of his tremor conflicts with that of his treating neurologist, Dr. Ungar-Sargon. Petitioner flatly denied having any tremor prior to the work accident but Dr. Ungar-Sargon testified otherwise:

> "[Petitioner] had this tremor before the accident although he does tell me it was made worse by the accident. He kept insisting on that."

Petitioner's testimony concerning the extent of his tremor also conflicts with Dr. Ungar-Sargon's records. Petitioner insisted he experiences tremors only in his right hand and arm but Dr. Ungar-Sargon's initial history of March 11, 2015 reflects that Petitioner complained of

tremors in multiple body parts. Under cross-examination, Petitioner testified he was honest with his treating physicians. He expressed the belief that Dr. Ungar-Sargon made a mistake when recording his tremor-related complaints. The Arbitrator does not share Petitioner's belief on this point.

Arbitrator's Conclusions of Law

Did Petitioner sustain an accident on April 9, 2014 arising out of and in the course of his employment?

The Arbitrator finds that Petitioner met his burden of proof on the issue of accident. Petitioner's testimony concerning the circumstances of the accident and the mechanism of injury was detailed and corroborated by his treatment records. This testimony establishes Petitioner was on the clock, performing a work-related task, at the time of the accident. Respondent provided an Employer's First Report of Injury to its second examiner, Dr. Levin, but did not offer this document into evidence. Respondent did not call any witnesses to contradict Petitioner's account of the accident.

Did Petitioner establish a causal connection between his April 9, 2014 accident and his current claimed conditions of ill-being?

The Arbitrator finds that Petitioner established causation only as to the following conditions: a brachial plexus and/or shoulder condition, bicipital tendonitis, a cervical strain superimposed on a pre-existing, post-fusion condition and a lumbar spine condition with a left-sided radicular component. The Arbitrator views this radicular component as not significant, disability-wise, since Petitioner's dorsiflexion weakness is in his right foot, according to Dr. Carlson. PX 4. The Arbitrator attributes Petitioner's documented gait issues to a pre-existing and progressive neurological condition, whether Parkinson's or otherwise, that is unrelated to the work accident. See further below.

In finding causation as to a brachial plexus and/or shoulder condition, the Arbitrator relies on the opinions expressed by Dr. Ross, Respondent's first examiner, and the opinions expressed by Dr. Ungar-Sargon. In finding causation as to bicipital tendonitis, the Arbitrator relies on the opinions expressed by Dr. Ungar-Sargon. The Arbitrator also relies on Petitioner's credible description of the mechanism of injury. Petitioner indicated he was squatting next to a manhole, holding a 4-inch hose in his hands, when the hose suddenly moved, causing Petitioner's head to be pulled backward while his body was pulled forward, with Petitioner having to avoid falling into the manhole. This mechanism could certainly have caused a "stretch" type of injury to the brachial plexus and an injury to the biceps. The Arbitrator views Petitioner complaint of right upper extremity weakness as multi-factorial, with both his underlying, as yet undiagnosed neurological condition and his work-related brachial plexus injury and bicipital tendonitis contributing to the weakness.

In finding causation as to cervical and lumbar spine conditions of ill-being, the Arbitrator relies on the following: 1) Dr. Carlson's records, which document neck and back complaints from April 11, 2014 forward; 2) Dr. Ungar-Sargon's opinions; and 3) the March 20, 2015 EMG, which showed focal left lumbar radiculopathy.

The Arbitrator further finds that Petitioner failed to establish causation as to any tremor-producing neurological condition, whether Parkinson's or otherwise. Petitioner was not credible when he insisted his tremor started immediately after the accident and was confined to his right hand. His own physician, Dr. Ungar-Sargon, acknowledged that Petitioner reported having a tremor before the accident. That same physician recorded complaints of tremors in various body parts on March 11, 2015. PX 1, pp. 1-3. It may well be that Petitioner's pre-existing neurological condition progressed after the work accident but there is no credible evidence indicating that the accident caused or accelerated the progression. Dr. Ungar-Sargon acknowledged he does not know the cause of Petitioner's tremor.

The Arbitrator also finds that Petitioner failed to establish causation as to the carpal tunnel syndrome diagnosed by Dr. Ungar-Sargon. The doctor testified this condition could be related to Petitioner's occupation but he did not link it to the accident.

Is Petitioner entitled to temporary total disability benefits? Is Petitioner entitled to prospective care?

Petitioner claims he was temporarily totally disabled from April 10, 2014 through the hearing of September 28, 2015. Respondent disputes this claim and claims an overpayment of temporary total disability benefits. Arb Exh 1.

Petitioner's overall appearance at the hearing leads the Arbitrator to conclude he is totally disabled. Petitioner exhibited a significant tremor in his right hand and arm, as well as difficulty rising out of his chair and walking a short distance in the hearing room. His affect was flat.

The Arbitrator attributes some of Petitioner's current total disability to his underlying, unrelated neurological condition, whatever that condition may be. The Arbitrator is not a physician but feels strongly that Petitioner, for his own sake and independent of this claim, with no liability on Respondent's part, should consult a board certified neurologist who specializes in movement disorders and practices in a university setting with access to medication trials. To the Arbitrator, it is the effects of the condition, rather than the condition's diagnostic label, that should matter at this point. As stated above, the Arbitrator does not attribute Petitioner's tremor and significant gait disorder to the accident. For Petitioner to continue a regimen of narcotic pain medication and give no consideration to alternative or additional medication that could address his tremor and mobility issues, makes no sense to the Arbitrator.

The Arbitrator finds that Petitioner's accident-related cervical and lumbar conditions have stabilized but continue to require some form of pain management. The Arbitrator finds it

reasonable for Dr. Ungar-Sargon to have administered one lumbar injection, on April 1, 2015, but finds it unreasonable for the doctor to have administered two additional injections in May and September 2015. Dr. Ungar-Sargon testified that Petitioner had a positive response to the first injection but Dr. Carlson's records tell a very different story, with the doctor indicating the first injection was "to no avail." The Arbitrator finds that Petitioner's shoulder/brachial plexus injury is unstable and requires evaluation and treatment. Because the Arbitrator views Petitioner's shoulder/brachial plexus injury as accident-related and unstable as of the hearing, and based on Interstate Scaffolding v. IWCC, 236 Ill.2d 132 (2010), the Arbitrator awards temporary total disability benefits from April 10, 2014 through the hearing of September 28, 2015, with Respondent receiving credit for the $26,192.25 in benefits it has paid. Arb Exh 1.

Petitioner seeks prospective care in the form of ongoing management by Drs. Carlson and Ungar-Sargon. The Arbitrator declines this request because she views neither of these physicians as sufficiently qualified or specialized to address Petitioner's needs. There is no evidence indicating Petitioner is improving under their care. At each visit, including the most recent visit of September 2, 2015, Dr. Ungar-Sargon documented complaints of very severe pain. The Arbitrator finds Respondent liable for prospective care in the form of an evaluation by a board certified, preferably fellowship-trained, physician who specializes in brachial plexus injuries.

Is Petitioner entitled to reasonable and necessary medical expenses?

Petitioner seeks an award of various medical and prescription bills. These bills are included in PX 5. The Arbitrator has reviewed all of the bills and compared them against the treatment records in evidence.

The Arbitrator awards the Franciscan Physician Network (Dr. Carlson) bills to the extent of Respondent's payment, i.e., $3,018.63, as documented in RX 1, on the theory that a paid medical bill is deemed to be reasonable and necessary.

The Arbitrator awards the Mea-Munster, LLC charges of $501.00, subject to the fee schedule and with Respondent receiving credit for the $450.90 payment it made to said provider. RX 1. These charges relate to care rendered at the Emergency Room on April 10, 2014. The charges are not supported by correlating medical records but both of Respondent's examiners referenced those records in their reports.

The Arbitrator awards the Imaging Associates of Indiana charges of $84.00, subject to the fee schedule and with Respondent receiving credit for the $80.33 payment it made to said provider. RX 1. These charges relate to cervical and lumbar spine X-rays performed on April 14, 2014.

The Arbitrator declines to award the $457.46 bill from Internal Medicine Associates for services provided by Dr. Venkatachalam. The bill in evidence contains no date of service. Nor does it contain any description of the services provided.

The Arbitrator awards the Munster Radiology Group charges of $77.00, subject to the fee schedule. These charges relate to shoulder and wrist X-rays performed at Community Hospital on April 10, 2014. The charges are not supported by correlating medical records but both of Respondent's examiners referenced the April 10, 2014 Community Hospital Emergency Room records in their reports.

The Arbitrator awards the Neurology & Pain Management Rensselaer (Dr. Ungar-Sargon) charges to the extent of $13,094.01, subject to the fee schedule. The Arbitrator declines to award the claimed charges of $2,879.80 relating to the injections Dr. Ungar-Sargon performed on May 6 and September 2, 2015.

The Arbitrator awards the incurred CVS prescription expenses of $91.99.

The Arbitrator awards the Merrillville Plaza Surgery charges of $225.00, the Merrillville Anesthesia charges of $1,225.00 and the Merrillville Plaza Surgery charges of $6,305.70, subject to the fee schedule. All of these charges relate to the lumbar injection and branch block Dr. Ungar-Sargon performed on April 1, 2015. The Arbitrator finds it reasonable for the doctor to have administered this care, given Petitioner's ongoing back complaints.

The Arbitrator declines to award the Merrillville Plaza Surgery charges of $4,352.85, $225.00, $225.00 and $1,350.00 relating to the lumbar injection Dr. Ungar-Sargon administered on May 6, 2015. The Arbitrator finds it not reasonable for Dr. Ungar-Sargon to have pursued additional lumbar injections after the injection of April 1, 2015, based on Dr. Carlson's records, which show that Petitioner described that injection as unhelpful. Petitioner did not testify to obtaining relief from any of the three injections he has undergone to date.

The Arbitrator finds it reasonable for Petitioner to have undergone cervical spine and lumbar spine X-rays at Franciscan St. Anthony Hospital on April 14, 2014 but does not award the $888.00 in charges relating to these X-rays because the explanation of benefits document in PX 5 shows a $0 balance. Respondent's print-out reflects a payment of $692.64 to Franciscan St. Anthony for services provided on April 14, 2014. RX 1.

The Arbitrator declines to award the Lab Pro expenses of $1,867.50 for services provided by Dr. Ungar-Sargon on July 1, 2015. The doctor's records reflect he refilled the Norco prescription and provided a cervical collar on July 1, 2015. It is not clear how these services correlate with $1,867.50 in charges. Petitioner did not testify to obtaining any durable equipment from Dr. Ungar-Sargon.

The Arbitrator awards the $478.00 charges of William Mason, M.D. relating to the CT scans Petitioner underwent on April 22, 2015, subject to the fee schedule.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Lavora Beene,
Petitioner,

vs.

Panduit Corp.,
Respondent.

17IWCC0041

NO: 08 WC 54944

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 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 17, 2016, is hereby affirmed and adopted.

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

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

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

DATED: JAN 25 2017
o1/18/17
RWW/rm
046

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

17IWCC0041

BEENE, LAVORA
Employee/Petitioner

Case# **08WC054944**

PANDUIT CORP
Employer/Respondent

On 2/17/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.41% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1920 BRISKMAN BRISKMAN & GREENBERG
RICHARD VICTOR
351 W HUBBARD ST SUITE 810
CHICAGO, IL 60654

1109 GAROFALO SCHREIBER HART ETAL
DANIEL L GRANT
55 W WACKER DR 10TH FL
CHICAGO, IL 60601

17IWCC0041

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

Lavora Beene Case # **08** WC **54944**

Employee/Petitioner

v.

Panduit Corporation
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Steven Fruth**, Arbitrator of the Commission, in the city of **Chicago**, on **June 19, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☒ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What 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 **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 **May 20, 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.

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

In the year preceding the injury, Petitioner earned **$28,662.40**; the average weekly wage was **$551.20**.

On the date of accident, Petitioner was **47** years of age, ***single*** with **1** dependent child.

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

ORDER

The Arbitrator finds that Petitioner failed to prove that she sustained accidental injuries on May 20, 2008 that arose out of and in the course of her employment for the Respondent. The Arbitrator further finds that Petitioner failed to prove that her condition of ill-being was causally related to her work activities on or about May 20, 2008.

Therefore, 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

February 16, 2016
Date

FEB 17 2016

ICArbDec p. 2

LAVORA BEENE v. PANDUIT CORPORATION
08 WC 54944

INTRODUCTION

This matter proceeded to hearing on June 19, 2015 before Arbitrator Steven Fruth. The disputed issues were: ***C:*** Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?; ***E:*** Was timely notice of the accident given to Respondent?; ***F:*** Is Petitioner's current condition of ill-being causally related to the accident?; ***J:*** Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?; ***K:*** What temporary benefits are in dispute? *TTD*; and ***L:*** What is the nature and extent of the injury?

FINDINGS OF FACT

Petitioner was a production operator for Respondent for 10 years. Petitioner testified that her job was comprised of 3 tasks: assembly, bagging, and packaging. She would rotate between the tasks, working no more than 2 to 3 days per week on any one task. Occasionally she would have to work at each task in one shift. She testified on cross–examination that she rotates between individual workstations for each task.

The assembly task involved working with small parts, and used her right arm to operate a lever to attach parts to a board constantly throughout the day. She demonstrated at trial how she used the lever, which was below shoulder level.

Petitioner testified that bagging involved picking up totes filled with assembled product off of a shelf, which was 5 or 6 feet tall. The totes weighed anywhere between 25 and 50 pounds each. She would have to lift approximately 2 to 3 totes per day, or approximately 6 totes per week. The only other task that she described at the bagging station involved pushing a button on a machine with her arms, which was done below the shoulder level.

The packaging station task involved taking the bagged parts and simply placing them into boxes. She then indicated that she would load the boxes into a tote and then load the totes onto a pallet. Occasionally she had to move the pallet with a dolly.

Petitioner testified that the only task that that required any overhead lifting was when she was required to lift totes off of a shelf 4 to 6 times per week. She did not describe any cross-body movements.

Petitioner first noticed pain in her shoulders on May 20, 2008. She had had pain before but on that day the pain was worse. She reported her complaints to her supervisor Jeff Miller. She told him that she needed to go to the hospital. On May 20

Petitioner I went to St. Francis Hospital, complaining of pain in her shoulders and her neck. She did not report that the complaints were related to her job duties. She then followed up with Dr. Berry, her primary physician. She followed with Dr. Berry at St. James Hospital. Dr. Berry managed her diabetes.

She had an EMG on June 19, 2008, ordered by Dr. Berry. She also had MRIs of both shoulders on August 29, 2008. She then followed for treatment at Roseland Community Hospital with Dr. Ivankovich from January 8, 2010 to February 22, 2013. She had additional MRIs of the shoulders. She received injections in her shoulders on in May 2011 in February 2015.

Dr. Ivankovich referred her for an FCE. He had also referred her to Dr. Johnson for consultation for surgery. Dr. Johnson determined to she was a poor surgical candidate due to her diabetes.

Petitioner testified that she has not returned to work since May 20, 2008. She was terminated by Respondent in November 2008 after her short-term disability ran out and her application for long-term disability was denied. She acknowledged that she did not claim her shoulder pain was related to work until after her disability application was denied. She was approved for Social Security disability benefits in 2015. Petitioner testified that she has continuing excruciating pain every day. She cannot lift anything up substantial weight and nothing overhead. Pain disrupts her every night.

Petitioner admitted that she did not file for Workers' Compensation benefits until after all of her disability benefits were terminated.

Dr. Davis had given her an OK for return to work on September 8, 2008. However, at that time she could not work. She testified that she had not seen Dr. Davis's report dated November 3, 2008. She testified that she did not file a lawsuit against Dr. Davis. She did not remember not putting forth full effort on the FCE. Dr. Ivankovich told her she could work light duty but she believes she cannot because of her pain and that she only gets 2 to 3 hours of work of sleep per night. Petitioner testified that she has not looked for alternative employment since 2008 due to her continuing complaints and work restrictions. She did acknowledge that none of her doctors have given her a total off work statement.

Testimony of Jeff Miller:

Mr. Miller was employed by Panduit as a production foreman in May of 2008. Petitioner reported to Mr. Miller. Mr. Miller testified that he did not recall Petitioner ever reporting an accident to him, or reporting any pain in her shoulders.

Mr. Miller testified that he oversaw production operators in 2008 and had performed the job himself from time to time in 2008. He testified that the job required little to no overhead lifting, and little lifting at all. The only overhead lifting was of boxes of labels at the packing station. With respect to the lifting requirements, Mr.

Miller testified that most of the lifting in 2008 was done by order picker, Dave Panny. In terms of the weights of the raw materials and the products, Mr. Miller testified that he personally weighed the products and analyzed the frequency with which those products would have been manipulated in the production process. This data was compiled and introduced as Respondent's Exhibit #5.

In terms of the overall job requirements, Mr. Miller testified that he had previously completed a job description form in 2008, (RX #4). Further, he testified that the job description form was a true and accurate depiction of the job requirements.

On cross-examination Mr. Miller stated that there was no difference between the job description and actual job activities. He also testified that he had observed Petitioner at work and that she did not make any physical complaints at work.

Testimony of Sandi VanWitzenberg:

Ms. VanWitzenberg testified that she a production operator for Respondent. She has been in that job for approximately 10 years, and worked in the same position as Petitioner in 2008. Ms. Van Witzenberg testified that the job is very easy, and consists of essentially 3 stations, those being assembly, bagging, and packaging.

Ms. VanWitzenberg testified that for the assembly job material handlers like Dave Panny bring the raw materials to the production operator's assembly stations and place them on the workstations. Assembly was done at waist level. She further testified that the assembly position involved snapping plastic components onto metal adapter panels and then, after those adapter panels were assembled, placing them in totes. The totes are then placed on one of the shelves of a cart that ran from floor height up to approximately eye level. There are 4 or 5 shelves on the carts. On an average day, production operators lift 4 to 6 totes, but only periodically would they use the top shelf level. Nearly all the lifting was done below the shoulder level. She did not testify whether the job required any cross-body movements.

Ms. VanWitzenberg also described the bagging process. The bagging position essentially required the operator to sit at a bagging station, place the finished product into bags, and then place them in the sealing machine that also labeled the bags. The most strenuous part of the job involved changing out the spools of bags, which occurred several times per shift. The bag spools were stored at approximately the ground level.

Ms. VanWitzenberg also described the boxing station. Operators would perform that job a couple times per week. The job simply required taking the finished bagged products from a tote at the waist level and placing them into boxes, and then placing the boxes onto a skid. She testified that the boxes weighed approximately one pound. That job did not require any overhead lifting or any cross-body lifting.

Testimony of Tim Hughes:

Mr. Hughes is employed by Respondent as a production operator. Mr. Hughes' job duties required him to perform material handling in 2008, train employees on the operations of machines, operate a machine, and also work as a production operator in the same process as the petitioner. He testified that he and Petitioner were work friends and would spend approximately 45 minutes per day together, which encompassed two breaks and lunch.

Mr. Hughes testified that before May 2008 Petitioner had said that if she was ever let go by Respondent that she would sue. These conversations were usually at the time of plant layoffs.

Petitioner rebuttal

In rebuttal Petitioner denied that she ever said anything to Mr. Hughes about suing Respondent. She reiterated that she told Mr. Miller that she was injured and wanted to go to the hospital.

Dr. Daniel Ivankovich (PX #3A &B & PX #9):

Dr. Ivankovich gave his evidence deposition on January 29, 2014 (PX #9). Dr. Ivankovich specializes in general orthopedics, but is not board certified in orthopedic surgery. His sub-specialty is trauma.

Dr. Ivankovich first saw Petitioner on October 5, 2010. She was complaining of bilateral shoulder pain. Dr. Ivankovich testified that initially they did not discuss Petitioner's work activities. Instead, they discussed her prior treatment and how the problems with her shoulders were affecting her activities of daily living. Dr. Ivankovich diagnosed her bilateral tendinitis, degenerative joint disease, and a possible rotator cuff tear. He administered a cortisone injection in the right shoulder and recommended occupational therapy. He also wanted updated imaging. He injected each shoulder on December 3, 2010, September 6, 2011 and December 9, 2011, and the right shoulder again on February 11, 2013.

Dr. Ivankovich opined that Petitioner suffered an aggravation of a work-related type injury due to repetitive motion and heavy overhead lifting. Dr. Ivankovich went on to state: "I do believe that my opinion that repetitive overhead activity, regardless of weight, 50 to 75 pounds, will exacerbate it quicker, but repetitive motions without rest, repetitive motions with overhead activity, 10, 20, 25 pounds, would be sufficient to aggravate and cause impingement and rotator cuff tears." (PX #9, p. 24)

On cross-examination, based on a hypothetical question, Dr. Ivankovich adjusted his opinions from focusing on repetitive overhead lifting to a possible single event (PX #9, p. 29,). Dr. Ivankovich testified that if all her job required her to lift was from time to time, then "it's not really a repetitive motion injury; rather, it's an isolated injury from lifting a weight or fixed type of weight. It can still be a rotator cuff tear." (PX #9, p. 36)

Dr. Ivankovich also related Petitioner's condition of ill-being to cross-body movement. (PX #9, pp. 30-31) He assumed that "she is manipulating. She is going across her body. So at some point she is lifting and she is lifting poundage...What we're talking about, repetitive use of hands, grasping, dexterity and movement. She is still lifting poundage. Anything that's going to involve movement and motion of her arm will involve her shoulder."

Dr. Ivankovich testified that simply because, in the course of doing whatever her job was as a production operator, Petitioner was using her upper extremities. "Do I believe the shoulders could have been aggravated in that type of work, lifting 20 to 50 pounds with repetitive motion? Yes." (PX #9, p. 32)

Dr. Ivankovich testified that his causation opinion was based on Petitioner's history and the information that he received from the FCE, which he confirmed was not from Panduit. "The finer motions and movements, no, I do not know what the fine, fine type of activities were. I don't know that. All I knew was the magnitude of the weight she was lifting and the type of job she did on the production line" as described by the petitioner. (PX #9, p. 33)

In answer to a question of whether Petitioner's job required less lifting than she described, he stated, "I think the type of lifting and the magnitude of the weight she was lifting would absolutely affect the type of injury or the type of pathology that was created." (PX #9, pp. 33-34)

Testimony of Dr. Guido Marra (RX #6):

Dr. Marra testified at evidence deposition at his on June 2, 2014. He is a board certified orthopedic surgeon. He examined Petitioner pursuant to §12 of the Act on July 2, 2009.

Petitioner complained of pain in both shoulders due to repetitive work activities. She gave a history of working as a machine operator for 9 years. Petitioner described her position as a manual labor position, which approximately 50% of the work was done overhead, and that her lifting was heavy – between 50 and 75 lbs. Petitioner stated that most work above the shoulder level was around 40 lbs.

On examination Dr. Marra did not find any muscle atrophy. Shoulder range of motion was diminished. There were positive impingement and rotator cuff signs in both shoulders. Dr. Marra noted that Petitioner was diabetic. He noted that diabetes can

affect the healing process, as it will delay the body's response to the healing process. Dr. Marra diagnosed impingement syndrome of both shoulders.

Dr. Marra reviewed various medical records and charts from Petitioners other treating physicians and other records: Dr. Davis, Dr. Ahmed, Dr. Hedayati, MRIs of the shoulders from August 2008, St. Francis Hospital, Rehab Services of Metro South, consultation reports from Dr. Shin and a job description of Petitioners employment. Dr. Marra also reviewed the FCE report. He wrote an addendum report on July 12, 2010.

Dr. Marra testified that, for a rotator cuff injury, the arm in a position that puts stress on the rotator cuff enough to cause an injury. In general, that involves using weights in an overhead position which would push the rotator cuff in a position where it's being squeezed, which can lead to an injury.

Dr. Marra opined that, if Petitioner's job did not require a significant amount of overhead work, then her shoulder conditions would not be related to her work. Conversely, if she was required to do a lot of overhead work, then the shoulder problems would be related to work. Dr. Marra noted that he reviewed a detailed job description of the position of a production operator. He opined that if the job description is accurate then Petitioner's work activities were not competent to cause rotator cuff tears or impingement. He also based his opinion on the absence of Petitioner reporting an injury or trauma to her treating physicians.

On cross-examination, Dr. Marra admitted that a person who has diabetes, and did extensive and repetitive lifting, was predisposed to developing rotator cuff pathology. However, Dr. Marra further testified that, even with individuals who have diabetes, the job still must require significant overhead work for that to lead to the development of rotator cuff pathology.

Dr. Marra also admitted that if, in fact, Petitioner had to lift 40 lbs. overhead repetitively at work he might change his causation opinion.

St. Francis Hospital and Health Center (PX #9)

Petitioner was seen in the Emergency Department at St. Francis on May 20, 2008. She was seen by Drs. Henry Shin and Faranza Iqbal. Petitioner complained of chronic intermittent neck pain, bilateral arm pain with numbness, and occasional numbness in her left calf. Petitioner also complained of chest pain. Petitioner reported that these episodes had been occurring for several weeks. She gave a history that she had been previously diagnosed with arthritis, and was diabetic. There was no documented history of injury or trauma. There was no documented complaint that Petitioner related her problems to work activities.

She was discharged with a diagnosis of atypical chest pain, degenerative joint disease, diabetes, and anemia.

Petitioner was examined by various physicians: Sohail Ahmed, M.D.; James Davis, D.O.; and Hadi Hedayati, M.D.

Petitioner saw Dr. Ahmed on June 19, 2008 for a neurological consultation on referral from Dr. Jennette Berry. Petitioner presented with complaints of pain in the extremities with numbness and tingling. She had a history of diabetes and arthritis. She reported that her current symptoms started about a month before and had come on gradually and then got worse. She had pain in her shoulders which then involved the arms. She complained of numbness and tingling in her fingers and her toes. Petitioner reported that she worked with machinery and packaging. She did not relate her complaints to her work activities. Dr. Ahmed recommended and EMG of her extremities as well as a battery of blood tests.

Petitioner saw Dr. Hedayati for a rheumatology consultation on July 30, 2008, on referral from Dr. Berry. Her history of diabetes with diabetic neuropathy and osteoarthritis was noted. Petitioner reported that she had developed some pain in her shoulders bilaterally and in the arm as well as the hip and leg since May 2008. She reported that Dr. Ahmed had conducted an EMG which showed diabetic neuropathy. Period after examination and lab testing Dr. Hedayati diagnosed myalgia and arthralgia but of unknown etiology.

Petitioner returned to Dr. Hedayati on August 27, 2008. She continued to have shooting pain down her arms from her cervical spine, greater on the right than the left. She also complained of shoulder pain on movement. She also reported numbness and tingling in her hands and weakness in her grip strength. Hedayati offered continued pain management with Lyrica and sulindac. He continued with his impression of bilateral shoulder arthropathy.

Petitioner saw Dr. Davis for an orthopedics consultation on September 15, 2008, also on referral from Dr. Berry. She gave a history of being on her way to work on May 20, 2008 when she began experiencing bilateral shoulder pain. On her arrival at work she had difficulty holding a cup of coffee and lifting her arm. Petitioner denied any injury or trauma to her shoulders. She also complained of neck pain and bilateral hand pain. She left work and went to the emergency room on that day.

Dr. Davis noted that Dr. Ahmed performed a bilateral EMG. Petitioner was told that she had bilateral upper extremity peripheral neuropathy secondary to her diabetes. Petitioner had also seen Dr. Hedayati, a rheumatologist. Dr. Hedayati told her serology testing was negative. Petitioner also reported that she had seen referring physician Dr. Jennette Berry again. Dr. Berry had ordered bilateral shoulder MRIs. Those were completed August 29.

On examination Dr. Davis noted positive impingement signs bilaterally. She also

had tenderness over the insertion of the rotator cuffs with the left more tender than the right. She had pain on testing of ranges of motion. Petitioner was also tender over both acromioclavicular joints. She had a negative crossover tests bilaterally. Dr. Davis noted the MRI showed bilateral rotator cuff tendinitis. He did not note visible tear rotator cuff tears. Dr. Berry prescribed anti-inflammatories and physical therapy.

Petitioner returned to Dr. Davis on November 24, 2008. He noted his previous diagnosis of bilateral shoulder impingement. Petitioner reported that she still has significant pain in both shoulders, left worse than the right, after one month of therapy. On examination Petitioner had a positive Hawkins and near test signs. Shoulder ranges of motion were generally full except for left shoulder flexion. Dr. Davis continued with his diagnosis of bilateral shoulder impingement syndrome. He gave her another prescription for physical therapy and continued taking prescribed pain medication.

Physical therapy initial evaluation notes on October 20, 2008 documented the unknown origin of Petitioner's complaints. Petitioner denied a history of trauma.

Reports on shoulder MRIs were not included within PX #1. A report on a cervical MRI on March 26, 2009, ordered by Dr. Clay Canaday, was included within PX #1. Diffuse degenerative changes from C3 to C7 were noted.

On November 3, 2008 Dr. Davis prepared a MetLife Attending Physicians Report stating that Petitioner's condition was not work-related (PX #7, p. 75-78).

There are no chart notes by Dr. Jennette Berry in either PX #1 or PX #7.

Physical Therapy and Sports Injury Rehabilitation (PX #4)

Petitioner underwent a Functional Capacity Evaluation at PTSIR on November 13, 2012. She was referred by Dr. Ivankovich.

Petitioner gave a history of injuring both shoulders from performing repetitive tasks over a period of time at work. She stated that she began experiencing pain in both shoulders and her neck on May 20, 2008. Petitioner reported that she was off work 2 weeks before her employer referred her to Advocate in Orland Park. She had negative EMG there. She also reported MRIs of both shoulders showing possible rotator cuff tears or tendinitis. She had a cortisone injection from Dr. Davis and physical therapy. Petitioner also reported a series of cortisone injections every 3–6 months. She started with Dr. Ivankovich in 2010. Later MRIs of the shoulders showed a thick rotator cuff tear in the left shoulder and a partial rotator cuff tear in the left. She has continued to receive cortisone injections and physical therapy.

Petitioner described her work for Respondent as involving a high degree of repetitive hand motion. Petitioner was found to have put forth inconsistent effort, which led to an assessment of 66% validity. 70% or greater is considered indicative of

consistent effort. Pettioner was found to be capable of light work level. Her job demand was medium-heavy work level.

Roseland Community Hospital (PX #6)

Petitioner was seen in the Roseland Hospital Emergency Department on July 28, September 19, and October 12, 2010; April 27, and September 27, 2011; May 26, September 19, and October 6, 2012; February 22, 2013; February 20, September 30, and October 11, 2014; and January 10 and February 2, 2015.

None of these encounters were for complaints regarding shoulders or upper extremities. The great majority related to cold or flu or upper respiratory infection complaints. On September 19, 2012 Petitioner presented with complaints of chest pain which radiated into her left arm. She was evaluated for a possible cardiac event.

Petitioner was admitted to Roseland community Hospital on October 28, 2011 for gallbladder surgery. 2 detailed histories and physicals were documented by her treating physicians. Petitioner's history of diabetes and osteoarthritis was well documented. There was no documentation of a history of bilateral shoulder pain or arm pain or hand pain and numbness. There is no history of work-related injury or complaints involving the shoulders or upper extremities.

St. James Hospital and Health Centers-Olympia Fields (PX #2)

Petitioner presented to the Emergency Department on June 4, 2008. She had complaints of chest pain as well as pain and tingling in the arms and legs and feet since May 20, 2008. She gave a history of being admitted to St. Francis Hospital on May 20 and had a cardiac workup. Petitioner was discharged with the impression with the clinical diagnosis of diabetic neuropathy. She was advised to follow up with her primary care physician and was scheduled to see a neurologist.

Petitioner returned to the Emergency Department at St. James Hospital on January 30, 2009. She had complaints of bilateral shoulder pain since May 2008. A detailed history of Petitioner's efforts to seek a new orthopedic surgeon was documented. Petitioner was seeking an alternative orthopedist to Dr. Davis, against whom she had a pending lawsuit. She had been told that in order to obtain a referral to a new orthopedist you must come through the emergency department. Petitioner's history of prior care, including MRIs of her shoulders was well-documented. The August 2008 MRIs showed tendinopathy and partial rotator cuff tears in both shoulders. She was discharged with a referral to Dr. Anthony Brown.

Dr. Jennette Berry/Midwest Physician Center-Beverly (PX #8)

The vast majority of these records is comprised of laboratory testing results. There are consultation reports from Drs. James Davis, Sohail Ahmed, and Hadi Hedayati. The only clinical notes which may be attributable to Dr. Berry are handwritten. The handwritten notes, which are difficult to read, for November 25, 2008 and January 6, 2009 do document Petitioner's complaints of bilateral shoulder pain.

CONCLUSIONS OF LAW

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

The Arbitrator finds that Petitioner failed to prove that she sustained a repetitive injury that manifested on or about May 20, 2008. The Arbitrator further finds that Petitioner also failed to prove that her claimed injury arose out of and in the course of her employment by Respondent.

Petitioner and Respondent's witnesses testified to the physical requirements and movements of the job of production operator. All these witnesses were consistent in that part of their testimonies. The physical requirements and movements required of a production operator for Respondent were quite varied. It seems clear that the job of production operator was designed to avoid too much repetitive movement at any one task. Rotating production operators from task to task prevents a worker from performing repetitive movements that, if done too often, might lead to injury.

The evidence is quite clear that Petitioner did not perform repetitive motions during her job that would cause injury from those motions.

Another basis for finding no accident is the absence in most of Petitioner's medical records of a history that she related her shoulder complaints to work activities. The Arbitrator note that Petitioner's initial medical providers did not document any complaint by Petitioner that she thought her condition was work-related. It is compelling that Dr. James Davis opined in November 2008, in the MetLife Attending Physicians Report, that Petitioner's condition was not related to work.

The Arbitrator found Petitioner's credibility questionable. She testified to daily pain, sometimes excruciating. She sat through a lengthy hearing without exhibiting any behavior suggestive of her experiencing pain.

Finally, the Arbitrator does not find Dr. Ivankovich' s opinions persuasive. Dr. Ivankovich did not obtain and review Pettioner's other medical records. He relied on Petitioner's description of her work activities. Petitioner's history to Dr. Ivankovich was inconsistent with Petitioner's trial testimony, the testimonies of her co-workers at hearing, and the official job description. Opinions based on inaccurate or incomplete

facts are not reliable. Dr. Ivankovich's opinions are clearly based on inaccurate and incomplete facts.

Based upon review of the totality of the evidence, the Arbitrator finds that Petitioner did not sustain accidental injuries arising out of and in the course of her employment as a production operator for Respondent on May 20, 2008. The Arbitrator finds the opinions of Dr. Davis, and Dr. Marra more persuasive than those of Dr. Ivankovich.

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

The Arbitrator finds that Petitioner proved that she gave timely notice of an incident relating to her complaints to Respondent. Petitioner testified that she informed her supervisor Jeff Miller that she had shoulder pain on May 20, 2008 and that she need to go to the hospital. In fact, Petitioner did go to St. Francis Hospital that day. Mr. Miller testified that he did not remember that conversation.

Although Petitioner's testimony regarding notice of injury is vague it does meet the minimum burden of proof that timely notice was given.

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

The Arbitrator adopts the conclusions of law set forth in Section *C* of this Decision.

The Arbitrator finds that the opinion of Dr. Guido Marra that Petitioner's current condition of ill-being is not related to Petitioner's work activities more persuasive than the opinion of Dr. Ivankovich that the condition is related. Dr. Marra's opinion is based on a more thorough review of Petitioner's medical history and also on a more clear understanding of the physical requirements of Petitioner's job.

As stated above it is compelling that Petitioner's treating physician, Dr. James Davis, opined in November 2008 that her shoulder condition was not related to her work.

The Arbitrator notes that Petitioner was repeatedly and consistently diagnosed with peripheral neuropathy related to her diabetes. The Arbitrator also notes that Pettioner repeatedly and consistently complained of numbness and tingling in her feet when she sought medical care. It is more likely than not that Petitioner's comaplints are related to her diabetes. Her diabetes was so severe as to disqualify her from surgery.

Consequently, the Arbitrator finds that Petitioner failed to prove that her current condition of ill-being is causally related to her work activities.

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

In light of the Arbitrator's findings that Petitioner failed to prove that her medical condition arose out of and in the course of her employment and that she failed to prove that her medical condition was causally related to her employment, this issue is moot.

K: What temporary benefits are in dispute? *TTD;*

In light of the Arbitrator's findings that Petitioner failed to prove that her medical condition arose out of and in the course of her employment and that she failed to prove that her medical condition was causally related to her employment, this issue is moot.

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

In light of the Arbitrator's findings that Petitioner failed to prove that her medical condition arose out of and in the course of her employment and that she failed to prove that her medical condition was causally related to her employment, this issue is moot.

Steven J. Fruth, Arbitrator — February 16, 2016 (Date)

STATE OF ILLINOIS)
) SS.
COUNTY OF WILLIAMSON)

☐ 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

JOHN CASE,
Petitioner,

vs.

VIENNA CORRECTIONAL CENTER,
Respondent.

17IWCC0042

NO: 14 WC 29711

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 truncated of accident, medical expenses, TTD, and PPD and being advised of the facts and law, reverses the Decision of the Arbitrator, which is attached hereto and made a part hereof, as stated below.

On July 28, 2014, Petitioner participated in a voluntary weightlifting competition, held on Respondent's premises, during his lunch break. The purpose of the weightlifting competition, as Petitioner testified to, was to raise money for the Employee Benefit Fund and to promote awareness of the positive effects of exercising. While attempting to bench press 485 pounds, he experienced pain to his right shoulder and was subsequently diagnosed a full-thickness tear of the pectoralis major muscle. Petitioner underwent both corrective surgery and physical therapy before returning to full-duty work without restrictions on March 9, 2015. The Arbitrator found Petitioner's participation in the weightlifting competition was within the personal comfort doctrine. The Commission disagrees and finds Petitioner's participation in the weightlifting competition to be a voluntary recreational activity as contemplated by Section 11 of the Act.

Section 11 of the Act provides "Accidental injuries incurred while participating in voluntary recreational programs including but not limited to athletic events, parties, and picnics do not arise out of and in the course of employment . . . ." Section 11does not apply to when an employee is injured and is ordered or assigned by his employer to participate in the program. No evidence is presented that convinces the Commission that Petitioner's participation in the weightlifting competition was compulsory or even compelled by the application of any undue influence.

Petitioner affirmatively testified to other correctional officers and supervisors participating in the weightlifting competition. He did not indicate that he was ordered to

17IWCC0042

participate in the competition or that any of his own supervisors participated in the event and, in doing so doing, created an expectation for him to do so. He testified that about twelve individuals, representing less than one percent of Respondent's employees, participated in the competition. The paltry number of participants in the competition leads the Commission to conclude that Petitioner's participation in the weightlifting was not obligatory.

Jason Hall, who was present at Vienna Correctional Center when Petitioner was injured, testified on behalf of Respondent. On both direct examination as well as cross-examination, he testified that participation in the weightlifting competition was voluntary. He testified further that the weightlifting competition was not promoted by Respondent. The extent to which Respondent was involved in the weightlifting competition was that it allowed the competition to occur on its premises.

The Commission finds, by virtue of Petitioner's voluntary participation in the weightlifting competition on July 28, 2014, the injuries to his right upper extremity did not arise out of or in the course his employment. In so finding, the Commission finds Arbitrator Rowe-Sullivan's application of the personal comfort doctrine in this particular claim to be erroneous.

The personal comfort doctrine provides that an employee, "while engaged in the work of his or her employer, may do things that are necessary to his or her health or comfort, even though personal to himself or herself, and such acts will be considered incidental to the employment." *Illinois Consolidated Telephone Company v. Industrial Commission*, 313 Ill. App.3d 347, 350, 732 N.E.2d 49, 52, 247, Ill. Dec. 333 (5th Dist. 2000). Petitioner's regular, lunch hour practice of lifting weights could be plausibly found to be within the realm of an activity incidental to employment. Petitioner's as-testified-to reason for regularly lifting weights on his lunch hour was to maintain sufficient strength to allow him to physically assert control over and/or defend himself from inmates is credible. The Commission, however, draws a distinction between the weightlifting Petitioner regularly engaged in on his lunch hour and his voluntary participation in the weightlifting competition that took place at Vienna Correctional Center on July 28, 2014, and finds the latter to not be incidental to his employment as a correctional officer.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator dated March 10, 2016, concerning this matter is reversed and compensation denied.

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 2 6 2017
KWL/mav
O:11/29/16
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

17IWCC0042

CASE, JOHN
Employee/Petitioner

Case# **14WC029711**

SOI/VIENNA CORRECTIONAL CENTER
Employer/Respondent

On 4/6/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

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6 EXECUTIVE DR
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0502 STATE EMPLOYEES RETIREMENT
2101 S VETERANS PARKWAY
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0498 STATE OF ILLINOIS
ATTORNEY GENERAL
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CHICAGO, IL 60601

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

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

APR 6 – 2016

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

STATE OF ILLINOIS)
)SS.
COUNTY OF Williamson)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
CORRECTED ARBITRATION DECISION

17IWCC0042

John Case
Employee/Petitioner

v.

Case # 14 WC 29711

Consolidated cases: n/a

State of Illinois/Vienna Correctional Center
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 **Melinda Rowe-Sullivan**, Arbitrator of the Commission, in the city of **Herrin**, on **February 10, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

17IWCC0042

FINDINGS

On **July 28, 2014**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***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 **$63,664.00**; the average weekly wage was **$1,224.31**.

On the date of accident, Petitioner was **39** years of age, ***married*** with 3 dependent children.

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

Petitioner was temporarily totally disabled for the timeframe of August 13, 2014 through March 9, 2015.

Respondent is entitled to a credit for **all amounts paid under group health plan** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of **$816.21**/week for **29 6/7 weeks**, commencing August 13, 2014 through March 9, 2015, as provided in Section 8(b) of the Act.

Respondent shall pay **$36,202.78** for medical services as provided in Sections 8(a) and 8.2 of the Act. Respondent is to hold Petitioner harmless for any claims for reimbursement from any health insurance provider and shall provide payment information to Petitioner relative to any credit due. Respondent is to pay unpaid balances with regard to said medical expenses directly to the providers as stipulated by the parties at the time of arbitration. Respondent shall pay any unpaid, related medical expenses according to the fee schedule and shall provide documentation with regard to said fee schedule payment calculations to Petitioner.

Respondent is entitled to a credit for **all amounts paid under group health plan** under Section 8(j) of the Act.

Respondent shall pay Petitioner the sum of **$734.59/week** for a further period of **63.25 weeks**, as provided in **Section 8(d)2** of the Act, because the injuries sustained caused **12.65% loss of use of the person-as-a-whole.**

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

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

Signature of Arbitrator

4/5/16
Date

APR 6 - 2016

STATE OF ILLINOIS)
) SS.
COUNTY OF)
WILLIAMSON

☐ 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

JESSIE HARTWELL,

Petitioner,

17IWCC0043

vs.

NO: 15 WC 11533

STATE OF ILLINOIS/DEPARTMENT OF HEALTHCARE & FAMILY 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 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.

With respect to the issue of nature and extent of Petitioner's injury, the Commission modifies the award for permanent partial disability benefits from 15% loss of use of the right wrist/hand as provided in Section 8(d) (sic) to 10% loss of use of the right hand pursuant to Section 8(e) of the Act. The Commission considered all of the factors enumerated in §8.1b, of which no single factor is the sole determinant on the issue of permanency and finds the Arbitrator properly gave no weight to factor (i), the reported level of impairment since neither party offered into evidence a reported level of impairment pursuant to subsection (a). The Arbitrator placed significant weight on factor (ii), the occupation of the injured worker and the Commission also finds that to be a proper assessment since the Petitioner was employed as an Office Coordinator and he was able to return to work in that capacity without any restrictions or limitations, a fact which the Commission finds contributes to the modification of the award. In regard to factor (iii), the age of the employee, the Petitioner was 60 years old at the time of the injury and 61 years at the time of the hearing. The Arbitrator properly placed some weight on the fact that Petitioner is expected to continue to work with symptoms in his right hand and wrist

17IWCC0043

for several more years before retiring. With respect to (iv), Petitioner's future earning capacity, neither party offered any evidence to show Petitioner's future earning capacity would be impacted. Finally, with respect to (v), evidence of disability corroborated by the treating medical records, the Arbitrator noted that the Petitioner's subjective complaints are well-documented in his medical records throughout his treatment. The Commission placed more significant weight on the fact that Petitioner treated conservatively without surgery and conceded that the medications he takes are for his various conditions including his back and arthritis as well as any residual effects from the injury sustained to his right wrist, a fact corroborated in the medical records.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on July 6, 2016 is hereby modified as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $587.55 per week for a period of 20.5 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused 10% loss of use of the right wrist/hand.

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 26 2017
KLW/bd
O: 12/19/16
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

17IWCC0043

HARTWELL, JESSIE
Employee/Petitioner

Case# **15WC011533**

SOI/DEPT OF HEALTHCARE & FAMILY SERVICES
Employer/Respondent

On 7/6/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.34% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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ATTORNEY GENERAL
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PO BOX 19255
SPRINGFIELD, IL 62794-9255

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

JUL 6 - 2016

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

STATE OF ILLINOIS)
)SS.
COUNTY OF WILLIAMSON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

17IWCC0043

JESSIE HARTWELL
Employee/Petitioner

v.

STATE OF ILLINOIS/DEPT OF HEALTHCARE & FAMILY SERVICES
Employer/Respondent

Case # **15** WC **11533**

Consolidated cases: _____

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Christina Hemenway**, Arbitrator of the Commission, in the city of **Herrin**, on **April 14, 2016**. By stipulation, the parties agree:

On the date of accident, **September 11, 2014**, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned **$50,921.00**, and the average weekly wage was **$979.25**.

At the time of injury, Petitioner was **60** 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 **$587.55**/week for a further period of **30.75** weeks, as provided in Section **8(d)** of the Act, because the injuries sustained caused **15% loss of use of the right wrist/hand.**

Respondent shall pay Petitioner compensation that has accrued from **January 12, 2015,(Petitioner's last day of treatment)** through **April 14, 2016**, 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

July 3, 2016
Date

JUL 6 - 2016

STATE OF ILLINOIS)
) SS
COUNTY OF WILLIAMSON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE & EXTENT

JESSIE HARTWELL
Employee/Petitioner

17IWCC0043

v.

Case #: **15 WC 11533**

STATE OF ILLINOIS/DEPT OF HEALTHCARE & FAMILY SERVICES
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

The parties stipulated that the only issue in dispute is the nature and extent of Petitioner's permanent partial disability. The parties stipulated that Respondent has paid, or will pay, all related medical bills pursuant to the medical fee schedule as provided in Sections 8(a) and 8.2 of the Act. The parties further stipulated that Respondent would receive credit for all medical bills paid, including those paid under its group plan, for which they would receive a credit pursuant to Section 8(j) of the Act.

On his date of accident, Petitioner was 60 years old, single, with no dependent children. He was employed by Respondent as an Office Coordinator, and had been employed by Respondent for 16 years. On that date, Petitioner was putting files away, and when he opened a drawer the files leaned forward and he could not read the labels. He shifted, pried, and lifted the files back in one direction and his right wrist went out in the process. Petitioner is right-hand dominant. He testified he had no prior problems with his right wrist or hand, had never had treatment or diagnostic tests on his right wrist or hand, and had never had a worker's compensation claim for his right wrist or hand prior to this accident.

Following the accident, Petitioner's hand went completely numb, he was unable to grip things, and he had aching pain along the top and sides of his wrist. He sought treatment with Dr. Steven Young, a board certified orthopedic hand specialist, on October 8, 2014. Dr. Young offered to do a surgical repair of the ligament that was torn, but Petitioner declined. He testified he lived by himself, did his own cooking, and gave himself insulin shots, and did not want to be in a cast for six weeks while recovering from surgery.

Petitioner testified he still experiences discomfort while using his hand that goes into his wrist and fingers. His grip strength is weakened and his hand gets fatigued much faster. In his

job, Petitioner primarily does data input but also takes files out of cabinet drawers and puts them back in. He experiences pain trying to pull files out of drawers, especially if the drawer is overloaded. He also experiences tingling and burning up and down his finger, wrist, and the outer edge of his wrist. Petitioner testified he had difficulty bending his wrist and pushing any weight. The Arbitrator notes that during testimony he demonstrated a lack of range of motion, in that the right wrist did not bend back as far as the left wrist.

On September 11, 2014, Petitioner completed an Employee's Notice of Injury, which was consistent with his testimony and history to Dr. Young. PX2. On September 12, 2014, a Supervisor's Report of Injury was completed by Sherrie Runge, with a consistent history. PX3.

Following the accident, Petitioner sought treatment with Dr. Steven Young on October 8, 2014. He gave a consistent history of the accident and complained of pain in the first dorsal compartment of the right wrist, on the ulnar aspect of the wrist. Examination showed decreased flexion and extension, as well as tenderness over the first dorsal compartment, the scapholunate interval, and the ulnar snuffbox. Dr. Young's assessment was right wrist DeQuervain's tenosynovitis and right wrist pain. Dr. Young prescribed Mobic, a thumb spica splint, and occupational therapy. Petitioner attended therapy from October 14, 2014, to December 3, 2014, and reported no improvement. PX3.

Because Petitioner's pain persisted, Dr. Young recommended an MRI, which was done on December 22, 2014. The MRI revealed a complete tear of the scapholunate ligament with the scapholunate interval widened. It also revealed dorsal intercalated segment instability and extensor carpi ulnaris moderate tendinopathy. PX4.

On January 12, 2015, Petitioner returned to Dr. Young, who explained that his injury required right wrist scapholunate ligament repair and reconstruction. Petitioner called Dr. Young on January 15, 2015, and advised he did not wish to have the surgery, as he lived alone, was insulin dependent, and felt the risks outweighed the benefits. PX4.

Dr. Young testified by way of deposition on March 8, 2016. He is a Board Certified Orthopedic Surgeon with a subspecialty in hand and upper extremity surgery. The majority of his practice consists of taking care of problems related to the hand and upper extremity. He testified consistent with his treating records. PX5.

Dr. Young testified that the scapholunate ligament is a ligament in the wrist, on the thumb side, between the scaphoid bone and lunate bone. Its function is to restrain motion between the two bones and hold them in proper alignment, and it essentially holds the majority of the wrist bones in appropriate position. Dr. Young testified that Petitioner had a complete tear of the scapholunate ligament and that it was related to his work injury of September 11, 2014. He recommended surgery to either repair or reconstruct the ligament. PX5.

On cross-examination, Dr. Young testified that although Petitioner was initially diagnosed with DeQuervain's, his main issue was in fact the scapholunate ligament tear. He testified that a hyperextension injury at the wrist can cause such a tear, as could a twisting injury, and that Petitioner reported that he twisted his wrist trying to catch a cabinet drawer from a file.

Dr. Young acknowledged that a scapholunate ligament tear of this magnitude could occur degeneratively, in that the ligament can degenerate with time and disrupt. Dr. Young testified that the most common cause he sees for scapholunate ligament tears is an acute injury. PX5.

Dr. Young acknowledged that Petitioner had contacted his office to advise he did not want to proceed with surgery. He testified that without surgery Petitioner could see some improvement in symptoms, but that more than likely he would slowly develop advancing arthritic changes, lose some range of motion in the wrist, and have some chronic discomfort. He acknowledged Petitioner had pre-existing arthritic changes in his wrist which were fairly mild. Dr. Young testified Petitioner had not been examined since January 2015, and he would assume Petitioner had adjusted to his condition. He had not restricted Petitioner from work. PX5.

CONCLUSIONS OF LAW

The Arbitrator hereby incorporates by reference the Findings of Fact delineated above and the Arbitrator's and parties' exhibits are made a part of the Commission's file. The parties stipulated to all issues, including average weekly wage. The only issue in dispute at the time of trial was the nature and extent of permanent partial disability. With regard to the nature and extent of disability, for accidents occurring after September 1, 2011, pursuant to Section 8.1b of the Act, in determining the level of permanent partial disability the Arbitrator must look at the following five factors.

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

In regard to factor **(ii) the occupation of the injured employee**, the record reveals that Petitioner was employed as an Office Coordinator at the time of the accident and that he was able to return to work in that capacity without any restrictions or limitations as a result of said injury, and that he has received no complaints from his supervisor with regard to his job performance. Petitioner testified he uses his hands at work when doing data entry, when pulling files out of drawers, and when putting files into drawers. He further testified his right hand gets fatigued a lot quicker than before the accident, that he cannot bend his wrist or push weight on it as he used to, and that he has burning in his wrist. The Arbitrator finds it significant that Petitioner continues to work his full duties without restrictions, and also finds it significant that the he continues to have symptoms in his wrist and hand. The Arbitrator places significant weight on this factor.

In regard to factor **(iii) the age of the employee at the time of the injury**, Petitioner was 60 years old at the time of the accident and is currently 61 years old. He has been able to return to his prior position without limitation, although continues to have symptoms while working. Petitioner can be expected to continue working for another four to six years before retiring, likely in the same position. Due to the expected time Petitioner will continue to work with symptoms in his right hand and wrist, the Arbitrator places some weight on this factor.

In regard to factor **(iv) the employee's future earning capacity**, Petitioner has returned to his prior position full duty, with no limitations. Neither party offered any evidence to show that Petitioner's future earning capacity has been impacted, and the Arbitrator has no basis to expect he will have any decreased earning capacity in the future. The Arbitrator places some weight on this factor.

In regard to factor **(v) evidence of disability corroborated by the treating medical records**, the Arbitrator notes Petitioner's subjective complaints are well-documented in his medical records throughout his treatment. Dr. Young's note following Petitioner's final visit of January 12, 2015, documents he was still having quite a bit of pain, had tenderness on palpation of the scapholunate interval and scaphoid shift, and had some weakness. Petitioner credibly testified that he continues to have these same complaints. The Arbitrator places significant weight on the fact that Petitioner's complaints are supported by the treating medical records.

The Arbitrator notes that consideration of the factors enumerated in Section 8.1b does not simply require a calculation, but rather a measured evaluation of all five factors, of which no single factor is the sole determinant on the issue of permanency. Taking the above five factors into consideration, and based on the record in its entirety, the Arbitrator finds that Petitioner has sustained a 15% loss of use of the right hand (30.75 weeks) pursuant to Section 8(e) of the Act. The parties stipulated that Petitioner's average weekly wage was $979.25, and the Arbitrator finds that his permanent partial disability rate is $587.55 per week.

STATE OF ILLINOIS)
) SS.
COUNTY OF MC LEAN)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Sedenia Wigfall,

Petitioner,

vs.

NO: 12 WC 20857

17IWCC0044

Snyder & Agency, Inc.,

Respondent.

DECISION AND OPINION ON REVIEW

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

The Arbitrator noted in his Decision that the Respondent paid Petitioner temporary total disability and temporary partial disability until April 30, 2013, and that the Petitioner was at the point of maximum medical improvement as of May 1, 2013. For the reasons set forth below, the Commission modifies the Arbitrator's Decision by finding that the Petitioner was entitled to temporary total disability (or temporary partial disability for the periods of Petitioner's part-time employment with Respondent) from April 12, 2012 through April 23, 2013. The Commission's basis for modifying the award was the report of Dr. Narasimhulu Sarma dated April 23, 2013.

So that the record is clear, and there is no mistake as to the intentions or actions of this Commission, we have considered the record in its entirety. We have reviewed the facts of the matter, both from a legal and a medical / legal perspective. We have considered all of the testimony, exhibits, pleadings and arguments submitted by the Petitioner and the Respondent. One should not and cannot presume that we have failed to review any of the record made below. Though our view of the record may or may not be different than the Arbitrator's, it should not be

presumed that we have failed to consider any evidence taken below. Our review of this material is statutorily mandated and we assert that this has been completed.

Dr. Sarma, Respondent's expert, completed an Independent Psychiatric Evaluation report dated April 23, 2013 after meeting with the Petitioner. He noted that the Petitioner's chief complaints were bad headaches, dizziness, forgetfulness, depression, anxiety, feeling overwhelmed, and not having motivation to do anything. All of her symptoms began post-accident. Dr. Sarma wrote that on the Petitioner's self-scored test for depression, she scored 53 out of 60, indicating severe depression. Dr. Sarma opined that it was not apparent that the Petitioner was severely depressed, and that it was disproportionate to what he observed.

According to Dr. Sarma's rating scale for depression, the Petitioner scored in the mild range. She scored in the normal range for anxiety. She also scored in the mild cognitive impairment range for the mini-mental status exam. Dr. Sarma opined that the Petitioner's diagnosis was mild depressive disorder. The presumed concussion associated with her work accident was not a substantial contributing cause of the Petitioner's mild depression. Dr. Sarma noted that the Petitioner did not seem to develop the depressive symptoms until she stopped working.

Dr. Sarma reported that he did not notice that the Petitioner had memory issues, although she reported to have them. Further, her return to work of three hours per day, then five hours per day, and then the inability to work three hours per day is not consistent with someone having cognitive issues due to post-concussion syndrome. Dr. Sarma did not think that the Petitioner required work restrictions. The Petitioner reached maximum medical improvement ("MMI") as of the date of his evaluation with the Petitioner. Dr. Sarma opined that Petitioner did not show any clear-cut evidence of a serious psychiatric disability, and that her present symptoms were not related to her work injury. He further recommended that the Petitioner treat with a therapist, although that treatment would not be related to her work injury.

Dr. Sarma was deposed for this case. He testified that he has been board certified in general psychiatry and neurology since 1975, and certified in geriatric psychology since 2000. Dr. Sarma saw the Petitioner on one occasion on April 10, 2013. He reviewed the Petitioner's previous medical records before seeing her. He reviewed her CT scan and MRI/ diagnostic exams, which were not positive for any acute injury at all. (Dep. 8-16)

Dr. Sarma noted that the Petitioner gave the impression as though she was very depressed, but there was inconsistency between what the Petitioner said and what Dr. Sarma observed. He opined that the Petitioner actually had very mild depression. Dr. Sarma did not think that the Petitioner was psychiatrically unable to work. (Dep. 17-21)

Dr. Sarma testified that usually when someone has dementia, the cell volume in their brain decreases and the brain shrinks. But there was nothing to suggest that from the Petitioner's CT scan. An acute injury to the brain would always show up on a CT scan or MRI. However, the Petitioner's MRI and CT scans were normal. (Dep. 27-35)

17IWCC0044

Dr. Sarma further testified with respect to the Petitioner's cognitive abilities. Utilizing four separate tests, he did not note any cognitive defects. He performed an anxiety test on the Petitioner and determined that she had no significant expression of anxiety during the interview or on the testing. Dr. Sarma did a cognitive loss test on Petitioner which he opined is a good test for a person that is developing dementia. He did not find that the Petitioner had any cognitive deficit. (Dep. 45-52)

Dr. Sarma further testified that people who have concussions return to their normal functionality of the brain tissue. He also noted that depression can be caused by anything. A concussion could make someone depressed depending on the consequences of the concussion, but in and of itself, a concussion does not cause depression. Post-concussion syndrome should produce symptoms of loss of total functionality, but Dr. Sarma did not see those symptoms in the Petitioner. He noted that the Petitioner was actually able to work for one year post-injury, and that when she stopped working she became much more depressed. Dr. Sarma opined that the Petitioner's depressive symptoms started when she was told not to come to work anymore. (Dep. 61-67)

Dr. Sarma also testified that there was no clear-cut evidence of a serious psychological disability, and that the Petitioner's present symptoms were not related to her April 12, 2012 injury. He did not find any psychiatric symptoms or cognitive disability that would require the Petitioner to reduce her work hours. (Dep. 68-69)

On cross examination Dr. Sarma testified that the Petitioner's responses to his questions were not consistent with someone who has a cognitive disorder because people with cognitive disorders do not understand the questions. Furthermore, the Petitioner does not have a severe cognitive disability because she was well oriented to time, place, and person. (Dep. 92-97, 98-107)

Dr. Sarma also testified that the consequences of the injury should be consistent with the severity of the injury. Although the consequences of a minor injury could develop over time, they should be present and progressive. Dr. Sarma did not find any cognitive problems with the Petitioner and only mild depression. (Dep. 107-109)

On redirect Dr. Sarma stated: "I do not see any permanent impairment in terms of her ability to do things." (Dep. 111)

Based upon the totality of the evidence and the factual findings above, the Commission modifies the Petitioner's entitlement to temporary total disability/ temporary partial disability. The Commission otherwise affirms and adopts the Decision of the Arbitrator

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's Decision, filed on July 30, 2015, is hereby modified.

17IWCC0044

IT IS FURTHER ORDERED BY THE COMMISSION that the Petitioner was entitled to temporary total disability (or temporary partial disability for the periods of Petitioner's part-time employment with Respondent) from April 12, 2012 through April 23, 2013. As the Respondent paid the Petitioner through April 30, 2013, no further temporary benefits are owed.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $253.00 per week for a period of 37.5 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the 7.5% loss of the person as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the medical bills outlined in the Arbitrator's decision. The Respondent is entitled to a credit for any medical bills paid.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $10,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JAN 27 2017

O: 11/29/16
TJT/gaf
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WIGFALL, SEDENIA
Employee/Petitioner

Case# **12WC020857**

SNYDER & AGENCY INC
Employer/Respondent

17IWCC0044

On 7/30/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.14% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0564 WILLIAMS & SWEE LTD
DIRK MAY
2011 FOX CREEK RD
BLOOMINGTON, IL 61701

4967 LAW OFFICE OF PAUL O WATKISS
KEVIN DOYLE
1804 N NAPER BLVD SUITE 380
NAPERVILLE, IL 60563

17IWCC0044

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

Sedenia Wigfall
Employee/Petitioner

v.

Snyder & Snyder Agency, Inc.
Employer/Respondent

Case # **12** WC **020857**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Douglas McCarthy**, Arbitrator of the Commission, in the city of **Bloomington**, on **June 26, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **4/12/12**, 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 $**21,862.88**; the average weekly wage was $**420.44**.

On the date of accident, Petitioner was **61** years of age, ***married*** 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 $11,376.05 for TTD, $ for TPD, $ for maintenance, and $**9247.91** for other benefits, for a total credit of $**20623.96**.

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

ORDER

Temporary Total Disability

Respondent paid Petitioner temporary total disability and temporary partial disability until April 30, 2013. As stated in this decision, the Arbitrator believes the petitioner was at a point of maximum medical improvement as of May 1, 2013, and no further temporary benefits are owed.

Permanent Partial Disability: Person as a whole

Respondent shall pay Petitioner permanent partial disability benefits of $**253**/week for 37.5 weeks, because the injuries sustained caused the **7.5%** loss of the person as a whole, as provided in Section 8(d)2 of the Act.

Medical

Respondent shall pay petitioner the medical bills outlined in this decision. It is entitled to credit for medical it paid.

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

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

D. Dylan McCarthy
Signature of Arbitrator

July 27, 2015
Date

JUL 30 2015

Causal Connection

The parties stipulated to accident in this matter. Petitioner, Sedenia Wigfall, testified that a framed picture weighing approximately eight pounds fell forward one to two feet and she was struck on the top of her head with the metal frame. Petitioner testified that it knocked her to the floor and hit the back of her head against a water cooler. Petitioner testified that she felt something like a shock of electricity in her head when this happened.

Ms. Wigfall went to OSF Occupational Health and the emergency room for evaluations. Petitioner also treated with a chiropractor for her neck pain from April, 2012 through August, 2012 (Px. 6). Petitioner was referred to a neurologist, Dr. Fang Li.

Dr. Fang Li testified that she first saw Ms. Wigfall on April 25, 2012 (Px. 1, p. 4). Dr. Li testified that she diagnosed Petitioner with post-concussive syndrome and depression with some anxiety (Px. 1, p. 8). Dr. Li explained that post-concussive syndrome exhibits symptoms of headache, cognitive impairment and sometimes a balance issue (Px. 1, p.8). Dr. Li testified that a normal MRI finding is consistent with post-concussive syndrome because it will not always show up (Px. 1, p. 8, 9). Dr. Li testified that she treated her depression and headaches with medications (Px. 1, p. 10, 11).

Dr. Li testified that, based on a reasonable degree of medical certainty, Petitioner's accident caused her concussive syndrome (Px. 1, p.12). Dr. Li testified that her opinion was based on her clinical findings, symptoms, and neuropsychological testing (Px. 1, p.12). Dr. Li testified that the traumatic event can trigger the mood or anxiety problem, especially if there is a cognitive issue (Px. 1, p.13). Dr. Li testified that her prognosis for Ms. Wigfall is slow improvement due to her age and the course of her response to treatments so far (Px. 1, p. 14, 15). Dr. Li testified that in her opinion Ms. Wigfall has dementia that is mild to moderate, but not severe, as per the independent medical examiner, Dr. Kohn (Px. 1, p.17).

Respondent's IME, Dr. Kohn, testified that the cause of all of Petitioner's problems is significant dementia (Rx. 8). Dr. Fang Li disagreed with his diagnosis and testified that Petitioner had mild to moderate dementia (Px. 1, p. 17). Petitioner testified that she did not believe she has severe dementia and she is able to stay at home during the day by herself and function independently. Respondent's other IME, Dr. Sarma, testified that there was no suggestion of dementia in Petitioner and that he disagreed with Dr. Kohn that Petitioner had a significant cognitive disorder (Rx. 9, p. 30, 52, 98).

Petitioner underwent a neuropsychological evaluation in November, 2012. It indicated that Ms. Wigfall has no impairment in language performance, moderate to severe impairment in word reading, borderline impairment in phonemic/lexical skills, moderate impairment in naming, no significant impairment in broad attention and working memory, simple information is processed quickly and efficiently, borderline level of impairment in executive functioning, especially for verbal information, and moderate levels of depression and severe levels of anxiety (Px. 5). The diagnosis from the neuropsychological evaluation includes post-concussive syndrome and adjustment disorder with mixed anxiety and depressed mood (Px. 5).

Dr. Sarma, Respondent's IME, testified that Ms. Wigfall has very mild depression (Rx. 9, p. 18). Dr. Sarma testified that Ms. Wigfall reported to him a general feeling of being overwhelmed (Rx. 9, p. 17). Dr. Sarma testified that anything, including trauma, can cause depression, but a concussion is only a temporary issue (Rx. 9, p. 63, 64).

Dr. Fang Li, Petitioner's treating neurologist, treated Ms. Wigfall from just after the work accident until present. She notes consistent symptoms of headaches, some cognitive impairment, depression and anxiety and dizziness. Ms. Wigfall testified to impairment with her symptoms over time. Dr. Fang Li indicates there has been slow improvement, maybe because of her age (Px. 1, p. 15). Respondent's independent medical examiners contradict one another and Petitioner's testimony. Dr. Kohn testified that all of Ms. Wigfall's problems are due to severe dementia, yet Dr. Sarma rejects this opinion. Ms. Wigfall testified that she does not have symptoms of severe dementia, and the neuropsychological test does not reveal severe cognitive impairment.

The Arbitrator finds that Petitioner suffered an accident, as that term is defined in the Illinois Workers' Compensation Act and that it has resulted in symptoms that are consistent with a concussion.

Medical

Based on the testimony of the witnesses and the medical records, the Arbitrator finds that Respondent is responsible for the payment of the following medical bills:

Petitioner has indicated **$7,083.31** in unpaid medical bills in Exhibit 8. In light of the Arbitrator's findings on causal connection, respondent is responsible for some of the bills. With respect to the bills which are the respondent's responsibility, it is entitled to credit for amounts paid under workers compensation and not entitled to credit for payments made by the petitioner's private insurance provider.

The petitioner states that **$608.50** remains unpaid from OSF St. Joseph Medical Center. Respondent has paid the vast majority of all bills from this provider. Plaintiff has included in this bill amount treatment from June of 2013 when the petitioner treated for a seizure. The total charge for this hospitalization is $46,732.60. It was paid by an insurance plan not obtained through the petitioner's employment. This is unrelated to the petitioner's 4/12/12 accident and therefore, not the respondent's responsibility. In addition there is a bill for pathology labs on October 3, 2013 in the amount of $515.00. The petitioner provided no explanation for the treatment, and the Arbitrator is unable to locate medical records corresponding to the charges. Accordingly, respondent is not responsible for them. The respondent is responsible for all of the other OSF charges and is entitled to credit for amounts paid under workers compensation.

The petitioner lists unpaid bills of **$489.81** from McLean County Neurology and **$1,925.00** from Child and Family Wellness Institute Psychology Specialists. Respondent does not dispute these bills.

The petitioner lists bills in the amount of **$3,383.00** from Normal Spine Clinic. The records do not contain an opinion that the treatment was related to the petitioner's accident. Further, the treatment focuses primarily on the petitioner's lower back. She did not complain of lower back. Her treatment is not causally related to her accident of April 12, 2012, and the bills are not the respondent's responsibility.

Petitioner lists **$677.00** in unpaid bills from Advocate Medical Group. These bills are for treatment received from March of 2014 until January of 2015. This appears to be the billing group for Dr. Li's practice at that time. The corresponding medical records from Dr. Li and his nurse practitioner show treatment for the petitioner's headaches and cognitive problems, which are related to her accident. Accordingly, they are the respondent's responsibility.

The petitioner is alleging **$1,624.53** in out of pocket expenses for the petitioner for medication and visits to her family physicians.. The respondent will reimburse the petitioner for those charges.

Temporary Total Disability

Dr. Fang Li took Petitioner off work and reduced her work hours for the period of April 12, 2012 through April 30, 2013. Respondent paid all necessary TTD and TPD. Respondent directed Petitioner to stop reporting for work on May 1, 2013. From then until the present time, Dr. Li has treated the petitioner's symptoms with medication. At her July 17, 2013 visit, the petitioner reported that her headaches were better with Depakote. Dr. Li testified that her post concussive symptoms should have reached a point of maximum medical improvement within 18 months of the accident. As stated above, he feels she is not totally disabled and testified that she could do a desk job. (PX 1 at 52-54) In an attorney conference note dated September 30, 2013, he said that her cognitive impairments from her concussion should improve. (PX 4) He testified that he did not believe her cognitive issues were progressive as she seemed to get better during the course of his treatment. (PX 1 at 44) Her daily activities reported at arbitration seem to support his opinions. While the evidence does not provide a

clear cut date for MMI, the Arbitrator believes that May 1, 2013 is an appropriate date. Accordingly, the respondent has paid all of the temporary benefits to which the petitioner is entitled.

Nature and Extent

Neither party submitted an impairment rating.

Pursuant to Section 8.16 of the Act, the Arbitrator has reviewed the following factors:

(i) Impairment rating: N/A

(ii) Occupation: Administrative Assistant

(iii) Age at the time of injury: 60 years old. The petitioner's expected work life is thus rather short. This factor favors the respondent.

(iv) Employee's future earning capacity: The petitioner's treating physician testified that she could perform a desk job, but based upon her subjective complaints; felt she was unable to perform her past work on a full time basis. There was no evidence offered to show any attempts at work since May 2013. This factor is neutral

(v) Evidence of disability corroborated with medical records:

Petitioner suffered post concussive symptoms, characterized as mild, with some cognitive deficits according to Dr. Li. (PX 1 at 39, 40) All of the petitioner's diagnostic examinations were negative. She continues to be symptomatic, which Dr. Li said was somewhat of a surprise. (Id at 26) His medical records to date do indicate that she needs to take medication for her headaches. As of her last reported visit on January 15, 2015, the petitioner reported that her memory had improved.

The Arbitrator finds that Petitioner is permanently partially disabled to the extent of 7.5 percent of the person.

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

Hugh James Robinson,

Petitioner,

vs.

NO: 09 WC 45865

The American Coal Company,

17IWCC0045

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of occupational disease, causal connection, statute of limitations, permanent partial disability, legal error, evidentiary error, Section 1(d) through Section 1(f) of the Workers' Occupational Diseases Act, and being advised of the facts and law, reverses the Decision of the Arbitrator as stated below.

For the reasons set forth below, the Commission reverses the Arbitrator's Decision by finding that Petitioner sustained an occupational disease in his employment with the Respondent, and by awarding permanent partial disability of 15% of the person as a whole.

So that the record is clear, and there is no mistake as to the intentions or actions of this Commission, we have considered the record in its entirety. We have reviewed the facts of the matter, both from a legal and a medical / legal perspective. We have considered all of the testimony, exhibits, pleadings and arguments submitted by the Petitioner and the Respondent. One should not and cannot presume that we have failed to review any of the record made below. Though our view of the record may or may not be different than the Arbitrator's, it should not be presumed that we have failed to consider any evidence taken below. Our review of this material is statutorily mandated and we assert that this has been completed.

The Petitioner testified on direct examination that he worked for 31 years as a coal miner, with the majority of the time working underground. He was exposed to coal dust, and breathed in silica dust, roof bolting glue fumes, and diesel fumes. The date of his last shift in the mine was August 18, 2009 for Respondent at the New Future mine. Petitioner worked in the safety department at that time. The day after his last day at the mine he underwent surgery for prostate cancer and never returned to the mine. (Tr. 7-10)

He further testified that he started working in the coal mine as a laborer (shoveling the coal onto the belts). Then, he ran a 'continuous miner' machine which cut coal at the face of the mine and is one of the dustier jobs in the mine. Petitioner also did roof bolting (drilling holes into the roof of the mine which would shoot silica rock dust down below) in order to hold up the roof of the mine. He would sometimes use glue with the roof bolting. The glue would sometimes bust, and the odor of the glue could be overwhelming. He then became a face-boss at the face of the mine, but he would still be located where the coal was being cut. That, in turn, caused coal dust. He also ran shuttle cars, which are the cars that take the coal from the continuous miner machine to the belts. He may have had other jobs as well. (Tr. 10-16)

Around 1975, the Petitioner transferred to another mine as a supervisor for three years working in the mine (as opposed to sitting in an office somewhere outside of the mine). Then he worked at two other mines in the 1980's. After the Freeman mine shut down, he worked as a truck driver for a short while. Then the Petitioner returned to the Freeman mine for a couple of years, then on to another mine for two years, and then to American Coal around 2000 until he left on August 18, 2009. (Tr. 17-19)

While the Petitioner worked at American Coal he was a supervisor underground, a mine manager, and a safety director. As safety director he went underground and inspected all areas of the coal mines. He also made the mine faces. He was exposed to fumes and dust because diesel shuttle cars and diesel ram cars were used. He could smell the emitting fumes even though they had 'scrubbers' on them. The Petitioner testified that there was always exposure to dust in the mine, especially where the machines were cutting coal. It was his job to be around the face of the mine, inspecting the equipment including the 'long wall' which put out more dust than the continuous miner did. The dust could be overwhelming at times because there was so much of it, even though they had the correct amount of air. There was exposure to the coal dust on the surface as well. (Tr. 19-22)

The Petitioner testified that he started to notice breathing issues around age 55. His breathing issues were keeping him from doing many things that he often used to do. It was taking him longer to do activities with his shortness of breath. He testified that at the time of his testimony he thought that he could possibly walk four blocks at a normal pace on level ground without becoming short of breath, and that he could walk 15 - 20 stairs before he had to stop and rest. His breathing problems have worsened since he started noticing them. Since he left the mine, his breathing problems have somewhat worsened. Petitioner does not take any breathing medications. He also testified that he has to stop when he is doing certain activities like mowing

the lawn and walking in order to catch his breath. His breathing issues have also affected his ability to golf, hunt, and fish because he cannot walk as far. The Petitioner also testified that has never smoked cigarettes. He previously had prostate cancer, and currently has high blood pressure and diabetes. (Tr. 22-26)

The Petitioner had chest x-rays taken on November 19, 2002, October 12, 2009, and June 17, 2010. Five certified B-readers provided their opinions on one or more of the aforementioned x-rays. There was also a B-reading by The National Institute for Occupational Safety and Health (NIOSH) on the November 19, 2002 x-ray. Five depositions of physicians were taken for this case: Dr. Dani Tazbaz, Dr. Mark Korte, Dr. Jerome Wiot, Dr. Jeff Selby, and Dr. Christopher Meyer.

Dr. Dani Tazbaz deposition

Dr. Tazbaz practices pulmonary medicine, but he is not a certified B-reader. He is board certified in internal medicine, pulmonary disease, and critical care medicine. Approximately 5-10% of his practice deals with coal miners. Prior to his current position, he worked with Dr. Cohen, who is the medical director of the black lung clinics of the nation. Dr. Tazbaz completed three years of training with Dr. Cohen, working with him in the black lung clinics. Dr. Tazbaz has had special training in reading x-ray studies for occupational lung disease and in performing pulmonary function testing on coal miners. (Dep. 4-6)

Dr. Tazbaz saw the Petitioner on March 9, 2010. He conducted a patient history, physical exam, and reviewed the Petitioner's chest x-ray. Dr. Tazbaz read the x-ray himself. (Dep. 7-8)

According to Dr. Tazbaz, Coal worker's pneumoconiosis ("CWP") can generally be considered an x-ray reading diagnosis. In order to have CWP, there has to be a tissue reaction to the coal dust trapped in the lungs. The tissue reaction is demonstrated by scarring or fibrosis. Sometimes there is an area of emphysema around the fibrosis or scarring. The scar tissue of CWP cannot perform the normal function of healthy lung tissue. Then, if a coal miner has CWP, they would have impairment in the function of their lungs at the site of scarring, whether it can be measured or not. (Dep. 8-10)

He further testified that a person with CWP could still have normal pulmonary function test results, normal blood gases, normal physical exam of the chest, and no complaints or symptoms. CWP is a chronic, slowly-progressive disease. A person with early stages of CWP might not know that he has it. Other exposures in the coal mine environment besides coal dust can cause lung disease or damage like silica, welding fumes, diesel fumes, fumes from high-sulfur coal fires, fumes from electrical cable fires, roof bolting glues, radon, aerosolized hydraulic fluid from brake lines, asbestos, bio-aerosols caused by the dust compression systems, lubricants, paints, and chemicals. (Dep. 10-12)

Dr. Tazbaz testified that based on Petitioner's x-ray that he examined and the Petitioner's coal dust exposure, the Petitioner has CWP which is radiographically significant. Dr. Tazbaz also opined that the Petitioner has chronic bronchitis and possible COPD, which would be related to his coal mining. He also opined that the Petitioner seemed to have chronic sinusitis, and that the coal mine environment could aggravate the sinusitis. (Dep. 22-25)

On cross examination, Dr. Tazbaz testified that the Petitioner's CWP diagnosis was based on his interpretation of the Petitioner's x-rays, his knowledge of the Petitioner's dust exposure, and the positive B-reading report. (Dep. 40-44)

Dr. Mark Korte deposition

Dr. Korte testified that he is a family practice physician and treats many present and former coal miners. He started treating the Petitioner on March 3, 2003. Numerous occasions were noted where the Petitioner was diagnosed with either sinusitis, upper respiratory infections, and/ or had complaints of a cough. Dr. Korte further testified that he could not opine that the Petitioner suffered any permanent functional impairment due to sinusitis. (Dep. 4-13, 27-34)

Dr. Jerome Wiot deposition

Dr. Wiot testified that he is board certified in radiology and works as a diagnostic radiologist. He reads 50-60 x-rays per work day. Dr. Wiot has been a certified B-reader since the 1970's. (Dep. 4-20, 27-29)

Dr. Wiot further testified that as CWP progresses, the profusion level increases. The profusion level refers to how many dots are on an x-ray. The standard for a positive CWP reading is 1/1. If the x-ray reader is sure that the film is positive, but doesn't quite meet the standard of 1/1 then it would be 1/0 (which is still a positive film). A reading of 0/1 is a negative film, but it was seriously considered to be a possible positive film. (Dep. 29-35)

On cross examination, Dr. Wiot testified that he cannot look at an x-ray and say without 100% accuracy that the person has CWP if it is the simple type. Likewise, CWP cannot be ruled out based on an x-ray because there could be changes caused by CWP that cannot be seen on the x-ray. He further testified that entries and treatment records of clear lungs on physical examination of the chest of a person with an x-ray consistent with CWP would not have anything to do with his B-reading. (Dep. 62-66)

Dr. Wiot also testified that the scarring and emphysema of CWP is permanent. The tissue with those issues does not have normal function. Then, if a person has CWP, they would have impairment in the function of their lungs at the site of scar tissue and emphysema, even though the impairment may not be measured by pulmonary function testing. A person can have CWP and a normal physical exam of the chest, normal pulmonary function testing, and normal arterial blood gas testing. (Dep. 68-70, 71-74)

Dr. Jeff Selby deposition

Dr. Selby testified that he is a pulmonologist, board certified in internal medicine and pulmonary diseases. He has been a B-reader since 1985. He works in private practice, treating patients who have lung diseases including CWP, but only about 5-10 of his patients have CWP. Dr. Selby reviewed the Petitioner's chest x-rays from October 12, 2009 and June 17, 2010. He opined that they were not indicative of CWP. (Dep. 3-7, 18-20)

On cross examination Dr. Selby testified that scarred lung tissue due to CWP cannot perform the function of normal, healthy tissue. Then, a person with CWP would have impairment in the function of their lung at the site of the scarring, whether the impairment could be measured by spirometry or not. The removal of further exposure to CWP is the only treatment for CWP - it does not have a cure. If a person with CWP continues to have exposure, it is generally considered a chronic, slowly-progressive disease. (Dep. 26-31)

On redirect, Dr. Selby noted that sinusitis is not a pulmonary impairment, and that anything can be an irritant to a particular person who has sinusitis (i.e. coal dust, mold, humidity). It is a temporary aggravation while the person is in that environment and will not cause any permanent aggravation. (Dep. 62-63)

Dr. Christopher Meyer deposition

Dr. Meyer testified that he is a radiologist, board certified in radiology since 1992. He's been a B-reader since 1999. Dr. Meyer reviewed the Petitioner's x-rays taken on November 19, 2002 and June 17, 2010, respectfully, and opined that CWP was not indicated. (Dep. 3-21, 40-41)

On cross examination, Dr. Meyer testified that in general, CWP would first manifest itself radiographically. Then it would later manifest itself in pulmonary function and/ or clinical abnormalities. Further, he stated that it is true that a miner with a 1/0 CWP level would probably not know that he has it. He also noted that two qualified and competent B-readers can reasonably disagree on B-readings of 1/0 versus 0/0. (Dep. 58-65, 87)

B-readings of November 19, 2002 x-ray

Dr. Henry Smith, a board certified radiologist and NIOSH certified B-reader, opined that this x-ray was positive for CWP. Dr. Michael Alexander, a board certified radiologist and NIOSH certified B-reader, opined that this x-ray was positive for CWP. Dr. Christopher Meyer, a board certified radiologist and NIOSH certified B-reader, opined that there was no evidence of CWP. A physician employed by NIOSH also reviewed this x-ray. NIOSH did not find the presence of CWP because the level of profusion was only 0/1. However, abnormalities - both small and large opacities - were noted in all of the Petitioner's lung zones.

B-readings of October 12, 2009 x-ray

Dr. Henry Smith opined that this x-ray was positive for CWP. Dr. Jeff Selby, board certified in internal medicine, pulmonology, and a NIOSH certified B-reader, opined that this x-

ray was negative for CWP. Dr. Jerome Wiot, a NIOSH certified B-reader, also opined that this x-ray was negative for CWP.

B-readings of June 17, 2010 x-ray

Dr. Smith and Dr. Alexander both opined that this x-ray was positive for CWP. Whereas Dr. Meyer and Dr. Selby both opined that this x-ray was negative for CWP.

Illinois Workers' Occupational Diseases Act

Section 1(d) states, in pertinent part:

> A disease shall be deemed to arise out of the employment if there is apparent to the rational mind, upon consideration of all the circumstances, a causal connection between the conditions under which the work is performed and the occupational disease. The disease needs not to have been foreseen or expected but after its contraction it must appear to have had its origin or aggravation in a risk connected with the employment and to have flowed from that source as a rational consequence.
> An employee shall be conclusively deemed to have been exposed to the hazards of an occupational disease when, for any length of time however short, he or she is employed in an occupation or process in which the hazard of the disease exists...If a miner who is suffering or suffered from pneumoconiosis was employed for 10 years or more in one or more coal mines there shall, effective July 1, 1973 be a rebuttable presumption that his or her pneumoconiosis arose out of such employment.

Section 1(e) states, in pertinent part:

> "Disablement" means an impairment or partial impairment, temporary or permanent, in the function of the body or any of the members of the body.

Section 1(f) states, in pertinent part:

> No compensation shall be payable for or on account of any occupational disease unless disablement, as herein defined, occurs within two years after the last day of the last exposure to the hazards of the disease.

Based upon the totality of the evidence and the factual findings above, the Commission finds that the Petitioner is entitled to workers' compensation benefits. The Commission therefore awards permanent partial disability benefits of 15% of the person as a whole. The Petitioner's diagnosis, supporting medical documentation, and his age at the time of his diagnosis are factors for this award. There was no assertion made by the Petitioner that a wage differential was the preferred award.

According to Section 1(f) of the Illinois Workers' Occupational Diseases Act ("Act"), a claimant must sustain a disablement within two years of their last exposure to the hazards attributable to their condition. The Petitioner left his mining job on August 18, 2009. The first positive B-reading for CWP that the Petitioner obtained was on October 21, 2009. Further, Dr.

Tazbaz diagnosed the Petitioner with CWP on March 9, 2010. Since the Petitioner obtained the CWP diagnoses within two years of leaving Respondent, he meets the requirement under Section 1(f) of the Act.

The Commission finds, by a preponderance of the evidence, that the Petitioner sustained the occupational disease of CWP through his employment with the Respondent. The Commission also finds that the Petitioner satisfied the two-year requirement under Section 1(f) of the Illinois Workers' Occupational Diseases Act.

The Commission further finds that the Petitioner's frequent sinusitis diagnoses were likely attributable to his work in the coal mines. However, according to Petitioner's physician Dr. Korte, there would be no permanent impairment from sinusitis. The Commission further finds that the Petitioner did not prove by a preponderance of the evidence that he suffered from chronic bronchitis or chronic obstructive pulmonary disease (COPD) as a result from working for Respondent.

The Commission finds that the Petitioner presented sufficient evidence to prove his claim: There were a total of five positive readings for CWP from the Petitioner's three x-rays, and Dr. Tazbaz, a pulmonary medicine specialist, also diagnosed the Petitioner with CWP. The Petitioner worked 31 years in the coal mines, and he was a non-smoker. The Petitioner testified to increasing difficulties with his ability to breathe while engaging in everyday activities. Furthermore, the B-reading findings from the Petitioner's November 19, 2002 x-ray were already borderline for CWP, even though that x-ray was taken 7 years before the Petitioner's last date of exposure. The B-reader for NIOSH indicated that there were small and large opacities seen in all of the Petitioner's lung zones. The level of profusion was 0/1. However, Respondent's expert Dr. Wiot testified that a 0/1 reading indicates that it was seriously considered that the subject might have CWP. Dr. Meyer, also Respondent's expert, testified that 0/1 is a mild abnormal reading.

The Commission finds that the Petitioner satisfies the requirement of Section (e) of the Act. The Petitioner testified to increased respiratory difficulties with daily life activities such as walking. Dr. Tazbaz testified that a coal miner with CWP would have impairment in the function of his lungs at the site of the scar tissue whether it can be measured or not. (Dep. 8-10) Respondent's experts Dr. Wiot and Dr. Selby also testified that a coal miner with CWP would have an impairment in the function of his lungs at the site of the scar tissue whether it can be measured or not. (Dep. 68-70), (Dep. 26-31)

The Commission finds that the Petitioner satisfies the requirement of Section (d) of the Act. It is apparent to the Commission that upon consideration of all of the circumstances, that Petitioner's CWP arose out of his employment as a coal miner, and that there is a causal connection between the conditions under which the Petitioner worked and CWP. He worked as a coal miner for well over the statutorily required 10 years, and he was diagnosed with CWP. According to Section (d), there is a rebuttable presumption that his CWP arose out of his

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employment in the coal mines. The Petitioner proved by a preponderance of the evidence that he was afflicted with CWP and that it arose of his employment.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's Decision, filed on August 20, 2015, is hereby reversed, as the Commission finds that Petitioner sustained an occupational disease that arose out of and in the course of Petitioner's employment with Respondent.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $664.72 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 Petitioner 15% loss of the person as a whole.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $50,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JAN 27 2017

TJT/gaf
O: 11/29/16
51

Thomas J. Tyrrell

Michael J. Brennan

DISENT

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

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ROBINSON, HUGH JAMES
Employee/Petitioner

Case# **09WC045865**

THE AMERICAN COAL COMPANY
Employer/Respondent

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On 8/20/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.24% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0755 CULLEY & WISSORE
KIRK CAPONI
300 SMALL ST SUITE 3
HARRISBURG, IL 62946

1662 CRAIG & CRAIG LLC
KENNETH F WERTS
PO BOX 1545
MT VERNON, IL 62864

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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

HUGH JAMES ROBINSON
Employee/Petitioner

v.

THE AMERICAN COAL COMPANY
Employer/Respondent

Case # **09** WC **045865**

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 **Michael Nowak**, Arbitrator of the Commission, in the city of **Herrin**, on **January 15 , 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

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FINDINGS

On **August 18, 2009**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did 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 **$75,000,12**; the average weekly wage was **$1,442.31**.

On the date of accident, Petitioner was **65** years of age, ***married*** with **0** dependent children.

Petitioner claims no medical.

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

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

ORDER

Because Petitioner failed to prove by a preponderance of the evidence that he suffered from an occupational disease which arose out of and in the course of his employment, that his condition of ill-being is causally related to the injury, and failed to prove a timely disablement as defined in Section 1(e), 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

8/12/15
Date

ICArbDec p. 2

AUG 20 2015

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FINDINGS OF FACT

Petitioner was 71 years old at the time of arbitration. He graduated from Herrin High School and has an associate's degree in commercial art and design from SIU Carbondale. Petitioner worked for about 31 years in coal mining with pretty much all of that time being underground. During his coal mining employment, in addition to coal dust, Petitioner was exposed to and breathed silica dust, roof bolting glue fumes and diesel fumes.

Petitioner's last day of exposure in the coal mine was August 18, 2009, at Respondent's New Future Mine. He was 66 years old on that date and his job classification was in the safety department. Petitioner testified that he was exposed to and breathed coal dust on that last day. That was his last day of work because he underwent surgery for prostate cancer the following day. He underwent three years of chemotherapy and never returned to the mine.

Petitioner was in the Air Force from 1962 to 1966. He then worked for three or four years at McDonnell Douglas in St. Louis designing aircrafts. He left there and started mining in 1971 for Ziegler Coal Company. While working at Ziegler, Petitioner's job classifications were laborer, continuous miner operator and roof bolter. Petitioner testified that the continuous miner actually cuts the coal out of the wall and is one of the dustier jobs in the mine. Petitioner testified that as a roof bolter, he would drill a hole up through the rock. Sometimes it would get clogged up and shoot all of the silica rock dust back down on him. He was also exposed to the roof bolting glue which is an epoxy type glue. It has an overwhelming smell. He also worked as a face boss and ran shuttle car at Ziegler. Petitioner went to work at Classic Coal in 1975 or 1976 as a supervisor. When that mine closed he went back to Ziegler for a while. He worked at Freeman in the 1980's doing the jobs described above. When Freeman No. 6 mine closed down, he drove a truck for a while and then was recalled to Freeman Coal in Farmington, Illinois for a couple of years. He worked at Rend Lake Consol Coal Mine for two or three years until it shut down. He started working for Respondent around 2000 and worked there until the time he left mining. At Respondent he worked as a supervisor underground and mine manager and then he became safety director. As safety director he went underground and inspected the coal mine to check for federal violations.

As safety director, Petitioner would go to all areas of the mine. He testified that the ram cars and shuttle cars ran on diesel so he could always smell the diesel fumes. Anytime he was underground he was exposed to dust, especially at the unit where the miner operators were cutting coal. He testified that he was exposed to quite a bit of dust. He did not know of any areas of the mine when he worked where he was not exposed to dust or fumes.

Petitioner testified that at around age 55, he started noticing that his breathing was keeping him from doing a lot of things that he "used to do pretty readily," and it was taking him longer to do them and he would get short of breath. He testified that he noticed these problems when he was doing his mine managing duties. Petitioner testified that as of arbitration he could walk at a normal pace on level ground four blocks before becoming short of breath. He could climb 10 to 15 stairs before stopping to rest. Petitioner testified that from the time he noticed onset of breathing problems at the mine until he left the mine, the problems got worse. Since leaving the mine, his problems have gotten somewhat worse. Petitioner testified that he has talked to his treating physicians at the VA Medical Clinic and Logan Primary Care about his breathing problems, but he has never taken any breathing medication. Petitioner has never smoked.

He testified that with his breathing problems it takes a lot longer to do a lot of things because he has to stop and rest and catch his breath. Petitioner testified that he cannot run. It has taken a toll on his golf game. He cannot walk as far when he hunts and fishes because of his breathing problems.

Petitioner applied for unemployment in October 2009 which he collected for a time. In 2010 he went to work teaching mining technology classes for Illinois Eastern Community College. He teaches classes at John A. Logan and Southeastern Illinois Colleges.

Dr. Dani Tazbaz evaluated Petitioner on March 9, 2010 at the request of Petitioner's attorney. Dr. Tazbaz is board certified in internal medicine, pulmonary disease and critical care medicine. (Petitioner's Exhibit No. 1, p. 5). Prior to moving to Carbondale, Dr. Tazbaz had three years of training in pulmonary and critical care medicine with Dr. Robert Cohen at Stroger Hospital. Dr. Cohen is the medical director of the Black Lung Clinics of the nation. (Petitioner's Exhibit No. 1, pp. 5-6). In that work, Dr. Tazbaz had special training and gained specific experience in reading radiographic studies for occupational lung diseases and in performing pulmonary function testing on current and former coal mine employees. (Petitioner's Exhibit No. 1, p. 6). Dr. Tazbaz is not a B-reader (Petitioner's Exhibit No. 1, p. 35).

Dr. Tazbaz testified that the diagnosis of coal workers' pneumoconiosis can generally be considered an x-ray diagnosis. (Petitioner's Exhibit No. 1, p. 8). Dr. Tazbaz testified that in order to have pneumoconiosis, there must be tissue reaction to the coal dust that is trapped in the lungs. This tissue reaction is called scarring or fibrosis. Dr. Tazbaz testified that the scarring of coal workers' pneumoconiosis is permanent. The scar tissue of coal workers' pneumoconiosis cannot perform the function of normal, healthy lung tissue. (Petitioner's Exhibit No. 1, pp. 8-9). Dr. Tazbaz concluded, based on all the data available to him, that Petitioner had coal workers' pneumoconiosis. (Petitioner's Exhibit No. 1, p. 22). He testified that by definition, if a miner has coal workers' pneumoconiosis, he would have impairment of his lung at the site of the scarring regardless of whether it could be measured or not. (Petitioner's Exhibit No. 1, pp. 9-10).

Petitioner told Dr. Tazbaz that he had cough for about two years. Dr. Tazbaz testified that people with chronic bronchitis have cough for two years. In this case, Petitioner carried a diagnosis of chronic bronchitis. Petitioner told Dr. Tazbaz that he could walk a mile and then he stopped. Petitioner did not specify whether it was fatigue versus shortness of breath that eventually stopped him. (Petitioner's Exhibit No. 1, p. 19). Dr. Tazbaz testified that Petitioner was 267 pounds and between 6'3" and 6'5". He described Petitioner as morbidly obese. Dr. Tazbaz's physical examination of Petitioner's chest was normal. (Petitioner's Exhibit No. 1, p. 20).

Dr. Tazbaz testified that the pulmonary function testing revealed moderately severe reduction in the FVC and the FEV1. The FEV1/FVC ratio was normal. That finding is seen in individuals with obesity or with fibrosis of the lungs. Dr. Tazbaz testified that if Petitioner's total lung capacity was 88% when measured by Dr. Selby that would be a normal total lung capacity. (Petitioner's Exhibit No. 1, pp. 21-22). The results of his spirometry revealed no obstructive defect. (Petitioner's Exhibit No. 1, p. 34). Dr. Tazbaz testified that COPD and chronic bronchitis are the same. The cough being present for two years can go with COPD, but since Petitioner's spirometry did not show an increased ratio, if he does have it, it would be a mild case. (Petitioner's Exhibit No. 1, p. 23). Dr. Tazbaz testified that in a never smoking coal miner, his cough, chronic bronchitis and possible COPD were related to his coal mining. (Petitioner's Exhibit No. 1, pp. 23-24). Dr. Tazbaz testified that in light of the diagnosis of coal workers' pneumoconiosis and Petitioner's history of cough and chronic bronchitis, he should not have any further exposure to coal mine dust without endangering his health. (Petitioner's Exhibit No. 1, p. 24).

Petitioner did not tell Dr. Tazbaz that he left mining at the time he did upon the recommendation of a physician because of concern about his pulmonary health. He did not report to Dr. Tazbaz that he left mining at the time he did due to respiratory problems or that he was unable to perform the duties of the job he had in the mine at the time he last worked. (Petitioner's Exhibit No. 1, p. 33). Dr. Tazbaz testified that he did not remember what lung zones were involved on Petitioner's chest x-ray. He testified that coal workers' pneumoconiosis most commonly involves the lower lung zones. (Petitioner's Exhibit No. 1, pp. 37-38). He testified that the abnormality that he observed on the film could have been present for 20 years or more. He testified that for those individuals who develop coal workers' pneumoconiosis and cease their exposure, the disease is unlikely to progress. He could not say that it was progressing in Petitioner. (Petitioner's Exhibit No. 1, p. 39).

Dr. Tazbaz did not review any outside medical records concerning Petitioner other than perhaps the radiology report of Dr. Smith. He testified that treatment records are of value when evaluating a patient for occupational disease. (Petitioner's Exhibit No. 1, p. 39). Dr. Tazbaz testified that he felt Petitioner cannot do moderate or heavy labor primarily related to his body mass index. Dr. Tazbaz reported two diagnoses for Petitioner, coal workers' pneumoconiosis and sleep apnea. (Petitioner's Exhibit No. 1, p. 41). The diagnosis of coal workers' pneumoconiosis was based upon Dr. Tazbaz's interpretation of the chest x-ray coupled with his knowledge of Petitioner's dust exposure. (Petitioner's Exhibit No. 1, p. 42). He testified that sleep apnea had nothing to do with his work at the coal mine. (Petitioner's Exhibit No. 1, p. 43).

Also at the request of Petitioner's attorney Dr. Henry K. Smith, board certified radiologist and NIOSH B-reader, and Dr. Michael Alexander, board certified radiologist and NIOSH B-reader reviewed Petitioner's x-rays. Dr. Smith interpreted Petitioner's chest x-ray of November 19, 2002, as positive for pneumoconiosis, category 1/1 with P/S opacities in all lung zones. He made an identical interpretation of the chest x-rays dated October 12, 2009, and June 17, 2010. (Petitioner's Exhibit No. 4). Dr. Alexander, board certified radiologist and NIOSH B-reader, interpreted the chest x-ray of November 19, 2002, as positive for pneumoconiosis, category 1/0 with P/P opacities in all lung zones. Dr. Alexander noted that the June 17, 2010, chest x-ray was quality II due to being too dark and low contrast. He interpreted same as positive for pneumoconiosis, category 1/0 with P/T opacities in all lung zones. He noted on the B-reading form that the actual profusion may be slightly higher since the x-ray is dark.

Records from NIOSH were admitted into evidence. A chest x-ray taken on November 19, 2002, was interpreted by an A-reader as showing no abnormalities consistent with pneumoconiosis. A B-reader interpreted the chest x-ray as negative for pneumoconiosis, category 0/1 with S/T opacities in all lung zones. The B-reader noted the film was quality II duc to underexposure. Both NIOSH readers noted scarring or atelectasis in the left lower lung. (Respondent's Exhibit No. 7).

At the request of counsel for Respondent, Dr. Jerome F. Wiot reviewed a PA and lateral chest x-ray dated October 12, 2009. (Respondent's Exhibit No. 1, p. 48). Dr. Wiot testified that the films were slightly underexposed and showed evidence of poor processing. Dr. Wiot found no evidence of coal workers' pneumoconiosis on the films. He noted that there was calcification of the anterior longitudinal ligament of the thoracic spine which was not a manifestation of coal dust exposure. (Respondent's Exhibit No. 1, pp. 48-49). Dr. Wiot testified that one tends to overread an underexposed film. On same the normal vascular markings of the lung stand out even more than on a good quality study. (Respondent's Exhibit No. 1, p. 49).

Dr. Wiot was the Past President of the American Board of Radiology and served as an examiner for the board. (Respondent's Exhibit No. 1, pp. 11-13). Dr. Wiot was also the Past President of the American College of Radiology and as a member of the Task Force on Pneumoconiosis, he helped develop a weekend symposium

which eventually became the modern day B-reader program. (Respondent's Exhibit No. 1, pp. 13-19). Dr. Wiot has been teaching the B-reading program since the first weekend course was held in 1970. (Respondent's Exhibit No. 1, p. 37). Dr. Wiot has been a B-reader since the program started (Respondent's Exhibit No. 1, p. 27).

Dr. Wiot testified that in reviewing a film for the presence of pneumoconiosis, the reader looks at the profusion or degree of involvement as well as the opacity type (Respondent's Exhibit No. 1, pp. 31-32). Dr. Wiot testified that with coal workers' pneumoconiosis the vast majority of the opacities will be round with irregular opacities as a secondary type. (Respondent's Exhibit No. 1, p. 32). Dr. Wiot testified that the reader also indicates what lung zones are involved. Coal workers' pneumoconiosis invariably begins in the upper lung fields. When it progresses, it will move to the mid and lower lung zones. He testified that it is almost invariably worse in the top lung zones than in the bottom. (Respondent's Exhibit No. 1, pp. 33-34). Dr. Wiot testified that the scarring of coal workers' pneumoconiosis is permanent. By definition if a person has coal workers' pneumoconiosis, theoretically he would have an impairment in the function of his lungs at the site of the scar tissue even though that impairment may not be able to be measured by pulmonary function testing. (Respondent's Exhibit No. 1, p. 70).

Dr. Wiot testified that it is very important in reading chest x-rays to be able to understand what is normal and what is abnormal. He testified that one has to understand what is acceptable for normal before he can decide if the minor changes are significant. This understanding only comes with experience. (Respondent's Exhibit No. 1, pp. 38-39).

At the request of counsel for Respondent, Dr. Cristopher A. Meyer reviewed chest x-rays for Petitioner dated November 19, 2002, and June 17, 2010. Dr. Meyer testified that the 2002 film was a copy film with poor contrast that he rated as quality II. He rated the 2010 chest x-ray as quality III, which is still interpretable for pneumoconiosis, but it was overexposed with low lung volumes due to underinflation. (Respondent's Exhibit No. 8, p. 40). Dr. Meyer testified that the 2002 examination revealed a linear opacity at the left lung base that was atelectasis or linear parenchymal band. He testified that the lungs were otherwise clear and there was no finding of coal workers' pneumoconiosis on the 2002 chest x-ray. The chest x-ray from 2010 was unchanged from the first examination and again had a linear scar at the left lung base. (Respondent's Exhibit No. 8, p. 41). Dr. Meyer testified that the linear scar most typically is a post-inflammatory scar from a region of a prior infection like pneumonia. He testified that the fact that the same area was present eight years later meant that it was not atelectasis but was a linear scar. (Respondent's Exhibit No. 8, p. 41).

Dr. Meyer has been board certified in radiology since 1992. (Respondent's Exhibit No. 8, p. 7). Dr. Meyer has been a B-reader since 1999 (Respondent's Exhibit No. 8, p. 19). Dr. Meyer was asked to take the B-reading exam by Dr. Jerome Wiot (Respondent's Exhibit No. 8, pp. 19-20). Dr. Wiot was on the original committee that designed the training course which is called the B-reader program. (Respondent's Exhibit No. 8, p. 21). Dr. Meyer has recently been asked to have a more active academic role with the B-reader course. (Respondent's Exhibit No. 8, p. 32). Dr. Meyer testified that radiologists have a 10% higher pass rate on the B-reading exam than other medical specialties. In Dr. Meyer's opinion radiologists have a better sense of what the variation in normal is. (Respondent's Exhibit No. 8, pp. 34-35).

Dr. Meyer testified that the B-reader looks at the films of the lung to decide whether there are any small nodular opacities or any linear opacities and based on the size and appearance of those small opacities, they are given a letter score. (Respondent's Exhibit No. 8, p. 22). Dr. Meyer testified that specific occupational lung diseases are described by specific opacity types. Coal workers' pneumoconiosis is characteristically described by small round opacities. (Respondent's Exhibit No. 8, pp. 28-29). The distribution of opacities is also

described because different pneumoconioses are seen in different regions of the lung. Coal workers' pneumoconiosis is typically an upper zone predominant process. (Respondent's Exhibit No. 8, pp. 22-23). The last component of the lung involvement for the small opacities is the extent of the lung involvement or the so-called profusion. (Respondent's Exhibit No. 8, p. 23). Dr. Meyer testified that the profusion defines the density of the small opacities in the lung. (Respondent's Exhibit No. 8, p. 30).

Dr. Jeff Selby examined Petitioner at the request of Respondent's counsel on June 17, 2010. (Respondent's Exhibit No. 2, pp. 7-8). Dr. Selby is board certified in internal medicine and pulmonology. He has been a B-reader since 1985. (Respondent's Exhibit No. 2, p. 3). Dr. Selby has a general pulmonology practice that entails both inpatient and outpatient. He does all manner of consultation work as far as chest, lungs or breathing disorders. His practice also includes occupational lung disease including individuals with coal workers' pneumoconiosis. (Respondent's Exhibit No. 2, pp. 4-5).

Dr. Selby's examination included a complete occupational history, physical examination and various laboratory testing. Dr. Selby testified that Petitioner's chief complaint was diabetes. Dr. Selby testified that Petitioner really had no complaint about dyspnea on exertion or shortness of breath. (Respondent's Exhibit No. 2, p. 8). Dr. Selby testified that two of Petitioner's medications, Losartan and Bicalcutamide, have a side effect of cough and sputum production. (Respondent's Exhibit No. 2, pp. 8-9). He was not taking any medications for a breathing problem. (Respondent's Exhibit No. 2, p. 9). On review of systems, Petitioner denied chest pain, palpitations, wheezing, cough and shortness of breath. (Respondent's Exhibit No. 2, p. 9). Dr. Selby testified that the American Thoracic Society states that a cough and spit daily three months in a row in two consecutive years fulfills the minimum requirements for a diagnosis of chronic bronchitis. Dr. Selby testified that sinusitis and/or rhinitis are associated with chronic cough. He testified that cough itself is not an objective determinant of pulmonary impairment. (Respondent's Exhibit No. 2, p. 10). Dr. Selby testified that any aggravation of sinusitis or rhinitis by the coal mine environment was a temporary aggravation while Petitioner was in the mine and would not cause permanent aggravation of those conditions. (Respondent's Exhibit No. 2, p. 62).

Dr. Selby testified that his physical examination of Petitioner's chest was normal. (Respondent's Exhibit No. 1, p. 10). Petitioner's oxygen saturation was 95% which is normal. (Respondent's Exhibit No. 2, pp. 10-11). Dr. Selby testified that the EKG revealed an incomplete right bundle branch block. He testified that this is usually a disease of the blood vessel that was supplying nutrients to the conducting tissue that somehow has been obstructed, causing death to some of that tissue. He testified that this is an indicator that Petitioner could have some heart disease that could have a significant effect on his exercise tolerance and possible complaints of shortness of breath. (Respondent's Exhibit No. 1, pp. 11-12).

Dr. Selby testified that the resting spirometry he performed on Petitioner was not valid. He testified that this testing is effort dependent. (Respondent's Exhibit No. 1, p. 12). Dr. Selby also measured Petitioner's lung volumes. His testing was normal. The testing eliminated the presence of an obstruction or restriction in Petitioner. Dr. Selby also performed diffusion capacity analysis which was normal indicating that Petitioner did not have any significant scarring or loss of lung tissue. Dr. Selby testified that a normal diffusion capacity speaks well for the normal status of the lung function in an individual. (Respondent's Exhibit No. 2, p. 13). Dr. Selby testified that pulmonary function testing is more accurate than an x-ray for determining COPD. (Respondent's Exhibit No. 2, p. 61).

Dr. Selby also performed exercise testing on Petitioner. He testified that exercise testing is the best way to actually see the functioning of the heart and lungs together to produce the ability to exercise. (Respondent's Exhibit No. 2, p. 14). Petitioner's test was stopped in the middle of stage III. He only had about a minute or so to go to complete a usual standard exercise test. The reason for stopping the test was shortness of breath. Dr.

Selby testified that is a common reason for stopping testing. (Respondent's Exhibit No. 2, p. 15). The resting blood gases were normal. They remained normal with exercise. (Respondent's Exhibit No. 2, pp. 16-17). Dr. Selby testified that from a functional standpoint there was no pulmonary problem identified. (Respondent's Exhibit No. 2, p. 17). Dr. Selby opined that obesity was Petitioner's main limitation to exercise. (Respondent's Exhibit No. 2, p. 17). Dr. Selby testified that Petitioner had no limitation identified for any hard physical labor. (Respondent's Exhibit No. 2, pp. 17-18). He testified that Petitioner had the pulmonary capacity to perform any and all previous coal mine employment duties (Respondent's Exhibit No. 2, p. 58).

Dr. Selby reviewed chest x-ray of Petitioner dated October 12, 2009. He noted that same was grade II quality film because of underinflation. He found no abnormality consistent with disease, particularly pneumoconiosis. He testified that underinflation would have resulted from the failure to take a full and complete deep breath. (Respondent's Exhibit No. 2, p. 18). He testified that one has to be careful in reading such a film not to overread it. (Respondent's Exhibit No. 2, p. 19). Dr. Selby also interpreted a chest x-ray taken June 17, 2010. Said film was grade III because it was overexposed or too dark. Dr. Selby did identify some small streaking scars in the lateral left base that was thought to possibly be atelectasis, but there were no findings consistent with pneumoconiosis. (Respondent's Exhibit No. 2, p. 19). He testified that same is something that can be seen when an individual fails to take a full deep breath. He testified that Petitioner's obesity would have an effect upon his ability to breathe deeply. (Respondent's Exhibit No. 2, p. 20).

Dr. Selby also testified that for a person to have coal workers' pneumoconiosis, he must have coal mine dust in his lungs, and a tissue reaction is required. That tissue reaction is called scarring or fibrosis. By definition, if a person has pneumoconiosis, he would have impairment in the function of his lung at the very site of the scarring, whether that impairment could be measured by spirometry or not. (Respondent's Exhibit No. 2, pp. 25-26). Dr. Selby testified that there is no cure for coal workers' pneumoconiosis and removal from any further exposure is the only treatment. (Respondent's Exhibit No. 2, p. 30). If a miner leaves the mine with category 1 pneumoconiosis and does not have any more exposure, in the vast majority of cases it will not progress. (Respondent's Exhibit No. 2, p. 31). Dr. Selby testified that it is possible for a person to have radiographically significant coal workers' pneumoconiosis and have normal pulmonary function tests and arterial blood gas tests. (Respondent's Exhibit No. 2, p. 32).

Dr. Selby testified that Petitioner voluntarily stopped his exercise testing. He testified that Petitioner did not like to work very hard on the treadmill and he did not seem to work consistently for his spirometry. He also testified that Petitioner did not seem to work very hard to take a deep breath for an x-ray. Dr. Selby testified that Petitioner showed pretty consistent poor effort in the effort-dependent testing that was done. (Respondent's Exhibit No. 2, p. 47).

Medical records from Heartland Regional Medical Center were admitted into evidence. On August 30, 2005, Petitioner underwent an excision of a nose lesion. On the prior day, during his physical, it was charted that his pulmonary system was normal. (Respondent's Exhibit No. 3, p. 296). On the date of the surgery, the "Admissions History" charts that he has no respiratory problems. (Respondent's Exhibit No. 3, pp. 279-280). It is further charted that he does not smoke and that he does not have COPD or asthma. (Respondent's Exhibit No. 3, p. 280). On July 31, 2009, Petitioner had a consultation with Dr. Adiraju Palagiri. Petitioner was diagnosed with carcinoma of the prostate. During the consultation it was charted that Petitioner was negative for asthma, shortness of breath and chronic cough, wheezing or history of emphysema or respiratory problems. His lungs were clear. (Respondent's Exhibit No. 3, pp. 261-263). Petitioner underwent a chest x-ray on August 18, 2009. The reason for the study was preop. The impression was mild bibasilar compressive changes. Otherwise it was a normal chest. (Respondent's Exhibit No. 3, p. 250). On the same date Petitioner was seen by Dr. Maddipoti for cardiology consultation because of coronary artery disease and for a preop evaluation.

Petitioner was not having any symptoms like dyspnea. It was charted that he denied chronic cough. During examination of his respiratory system, his chest was clear to auscultation. (Respondent's Exhibit No. 3, pp. 257-259). On August 20, 2009, Petitioner underwent surgery for his prostate cancer. On that same date, Petitioner was seen by Dr. Herman Lyle for a consultation. Dr. Lyle charted that Petitioner denied dyspnea. He had a history of obstructive sleep apnea diagnosed about 1996. He also had a history of gastroesophageal reflux. He had not been found to have any coal workers' pneumoconiosis and had no history of cigarette smoking. Examination of his lungs revealed diminished breath sounds in the bases but no rales, rhonchi or wheezes and no pleural friction rubs. Dr. Lyle charted that the chest x-ray revealed some changes suggesting chronic obstructive lung disease. (Respondent's Exhibit No. 3, pp. 230-234). A CT of the abdomen and pelvis was performed on August 23, 2009. In same the radiologist noted linear scarring versus atelectasis at the lung bases. (Respondent' Exhibit No. 3, p. 141).

Medical records of Prairie Cardiovascular Consultants were admitted into evidence. Petitioner was seen on June 14, 2007, by Dr. Raja Maddipoti for a consultation due to chest discomfort. Except for recent sinus infection, a 10-system review of systems was negative. His chest was clear to auscultation on examination (Respondent's Exhibit No. 4, pp. 34-36). Petitioner was seen by Dr. Maddipoti in follow up on June 21, 2007. In review of systems, Petitioner denied chronic cough. On physical examination of his respiratory system, no intercostal retractions were noted and his chest was clear to auscultation. (Respondent's Exhibit No. 4, pp. 23-26). On August 18, 2009, Petitioner was seen by Dr. Maddipoti for a cardiology consultation and preop evaluation. He was not having any symptoms like dyspnea. On review of systems respiratory he denied chronic cough. On physical examination of the respiratory system there were no intercostal retractions noted and the chest was clear to auscultation. (Respondent's Exhibit No. 4, pp. 5-8).

Medical records of the VA Medical Center were admitted into evidence. Petitioner was first seen there on September 30, 2002 to establish care. He denied tobacco use and on examination his lungs were clear to auscultation bilaterally (Respondent's Exhibit No. 6, pp. 339-342). Petitioner was seen again on October 29, 2002. He related having a lot of coughing, especially at night. (Respondent's Exhibit No. 6, pp. 335-336). Petitioner returned on December 12, 2007. On that date he denied shortness of breath or cough. (Respondent's Exhibit No. 6, pp. 329-332). When Petitioner was seen on February 1, 2008, it was noted that he felt well and continued in his employment as a coal miner. He denied shortness of breath or cough. (Respondent's Exhibit No. 6, pp. 317-321). When seen on May 20, 2008, Petitioner denied shortness of breath, cough or sputum. (Respondent's Exhibit No. 6, pp. 309-311). On June 4, 2008, Petitioner called the medical center advising that his blood pressure medication had been switched a couple of weeks prior due to cough. He still had the cough with the new medication. He was prescribed Lisinopril on that date. (Respondent's Exhibit No. 6, p. 309). On December 24, 2008, Petitioner related that he felt good. He denied shortness of breath, cough or sputum. Examination of the chest revealed his lungs to be clear with air entry equal and bilateral. He had no crackles or rhonchi. (Respondent's Exhibit No. 6, pp. 298-300). Petitioner was seen on November 30, 2009. He reported that on that date he had been laid off from work. He related no shortness of breath, cough or sputum. (Respondent's Exhibit No. 6, pp. 260-262). Petitioner was seen on February 24, 2010. He related no dyspnea with usual activity. On examination his lungs were clear. (Respondent's Exhibit No. 6, pp. 257-258). Petitioner was seen on March 1, 2010. He was noted to be active in the activities of daily living. He related no shortness of breath, cough or sputum. Examination of chest revealed lungs to be clear with air entry equal and bilateral. There were no crackles or rhonchi. (Respondent's Exhibit No. 6, pp. 247-250). Petitioner is seen on June 15, 2010. On that date Petitioner denied any dyspnea. Physical examination of the chest revealed the lungs to have good bilateral air entry. (Respondent's Exhibit No. 6, pp. 218-219). Petitioner was seen on September 8, 2010. Review of systems on that date revealed no shortness of breath, cough or sputum. On examination the chest revealed air entry equal and bilateral with no adventitious sounds. (Respondent's Exhibit No. 6, pp. 202-205). Petitioner underwent a chest x-ray on March 28, 2011. The film was interpreted as

revealing stable plate-like atelectasis in the left costophrenic angle. There were no pulmonary masses or lobar consolidations. (Respondent's Exhibit No. 6, p. 2). Petitioner is seen on September 22, 2011. His review of systems respiratory revealed no shortness of breath, cough or sputum. Physical examination of chest revealed lungs to be clear with good air entry and no adventitious sounds. (Respondent's Exhibit No. 6, pp. 78-82). Petitioner was seen on October 24, 2012. Review of systems respiratory revealed no shortness of breath, cough or sputum. Examination of the chest revealed the lungs clear with good air entry bilaterally and no adventitious sounds. (Respondent's Exhibit No. 6, pp. 63-66). Petitioner was seen on May 10, 2013. On that date review of systems respiratory revealed no shortness of breath, cough or sputum. (Respondent's Exhibit No. 6, pp. 56-58).

Dr. Mark J. Korte is a family physician who has practiced with Logan Primary Care for 13 years. (Petitioner's Exhibit No. 2, pp. 4-5). Dr. Korte treated Petitioner from approximately 2003 to 2009. At that time he knew Petitioner to be a coal miner. (Petitioner's Exhibit No. 2, p. 6).

Dr. Korte responded to certain questions propounded by Petitioner's counsel in a letter dated February 26, 2014. In that letter Dr. Korte indicated that Petitioner had a chronic cough, sinusitis, recurrent acute sinusitis, chronic nasal drainage problems, chronic sinus problems and bronchitis. Dr. Korte indicated that these conditions were caused in part or aggravated and made worse by Petitioner's exposures as a coal miner. Furthermore, in light of these conditions, Dr. Korte noted that Petitioner would present a risk to his health in the form of increased potential for worsening of his condition if he had any further exposure to the environment of a coal mine. Dr. Korte also noted in the report that in the course of his treatment, Petitioner had history or findings of COPD which were caused by or made worse by his exposures as a coal miner. He also had history or findings of coal workers' pneumoconiosis which were caused in part or aggravated and made worse by his exposure as a coal miner. In light of this COPD and coal workers' pneumoconiosis, further exposure to the environment of a coal mine would present a risk to Petitioner's health in the form of an increased potential for the worsening of those conditions. (Petitioner's Exhibit No. 2, Deposition Exhibit No. 2).

Dr. Korte first saw Petitioner on March 3, 2003 to establish care. On that date physical examination of the chest revealed the lungs clear to auscultation without wheeze, rhonchi or rale. (Petitioner's Exhibit No. 2, pp. 7-9). On April 4, 2003, Petitioner complained of sinus congestion and was diagnosed with acute sinusitis. (Petitioner's Exhibit No. 2, p. 9). Throughout Dr. Korte's treatment of Petitioner, Dr. Korte performed numerous physical examinations of Petitioner's chest. No abnormalities were revealed by those examinations except for the lungs being positive for rhonchi on February 16, 2004. (Petitioner's Exhibit No. 2, pp. 10-11; Respondent's Exhibit No. 5, pp. 40, 45, 52, 61, 64, 74, 78, 109, 113-114, 116, 118, 120, 124, 126, 130, 137, 139, 141, 144, 163). According to Dr. Korte's records, Petitioner complained of cough on February 23, 2004. (Petitioner's Exhibit No. 2, p. 11). Petitioner complained of a productive cough on May 1, 2005. (Petitioner's Exhibit No. 2, p. 12). Petitioner was seen on November 6, 2005, with complaint of sinusitis, and he had a cough. (Petitioner's Exhibit No. 2, p. 14). On February 10, 2007, Petitioner was seen for an upper respiratory infection. It was noted he had a sometimes productive cough. (Petitioner's Exhibit No. 2, p. 16). Petitioner was seen again on May 30, 2007, for sinusitis and it was noted he had a positive history of cough. (Petitioner's Exhibit No. 2, p. 18).

Dr. Korte testified that there was a letter to him from Dr. Maddipoti, a cardiologist, dated June 21, 2007, where Dr. Maddipoti documented his workup. Dr. Maddipoti's review of systems respiratory revealed denial of chronic cough. Physical examination of the chest revealed the lungs clear to auscultation. (Petitioner's Exhibit No. 2, p. 21). Dr. Maddipoti authored another consult letter dated September 27, 2007. On that date Dr. Maddipoti conducted a review of systems and for respiratory, Petitioner denied chronic cough. Dr. Maddipoti's physical examination of the chest revealed no abnormality. (Petitioner's Exhibit No. 2, pp. 25-26). Dr. Korte testified that Petitioner returned on May 24, 2008, and on that date complained of sinusitis, cough and some face

pain. Petitioner denied shortness of breath. Dr. Korte's assessment was acute sinusitis. (Petitioner's Exhibit No. 2, pp. 27-28). Dr. Korte testified that sinusitis is a common condition that he treats in his patient population of about 5,000 patients. (Petitioner's Exhibit No. 2, p. 30). Dr. Korte could not say from the records he reviewed regarding Petitioner that he suffered any permanent functional impairment because of sinusitis. (Petitioner's Exhibit No. 2, p. 31). After reviewing all of his office notes, Dr. Korte testified that he never diagnosed Petitioner with COPD, chronic bronchitis or coal workers' pneumoconiosis. (Petitioner's Exhibit No. 2, pp. 31-32). Dr. Korte testified that if he wants to know whether someone suffers from a restriction in airflow or an obstruction in airflow, he does spirometry. He did not know what Petitioner's chest x-rays have been interpreted as revealing by NIOSH. (Petitioner's Exhibit No. 2, pp. 39-40).

CONCLUSIONS OF LAW

Issue (C): Did an occupational disease occur that arose out of and in the course of Petitioner's employment by Respondent?

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

The Arbitrator finds the x-ray interpretations by Drs. Wiot, Meyer, Selby and NIOSH to be more persuasive than the interpretations by Drs. Tazbaz, Smith and Alexander. Dr. Smith interpreted the 2002, 2009 and 2010, chest x-rays as being identical. Dr. Meyer also testified that the chest x-ray from 2010 was unchanged from that taken in 2002. Both films had a linear opacity of the left lung base which Dr. Meyer interpreted as most likely due to post inflammatory scar from a prior infection like pneumonia. An A- and a B-reader for NIOSH interpreted the November 19, 2002, chest x-ray as negative for pneumoconiosis. Drs. Smith and Alexander interpreted the same x-ray as positive for pneumoconiosis and found later films to be the same. The NIOSH interpretations were the only independent readings. The Arbitrator finds the NIOSH readings to be persuasive as NIOSH is concerned with making sure their reading is accurate as the employee's rights to move to a less dusty job are dependent on the interpretation. The Arbitrator finds that Petitioner's chest x-ray was negative in 2002 and since all of the B-readers who read serial films from 2002 to 2010 found the films to be stable and without change, the Arbitrator finds that Petitioner's chest x-ray was also negative as of 2010.

Dr. Tazbaz did not remember what lung zones were involved on the film that he reviewed. Dr. Wiot and Dr. Meyer testified that it is important to describe what lung zones are involved. Dr. Tazbaz did not describe the type of opacities, the location of his findings or the profusion. Dr. Meyer and Dr. Wiot testified that these findings are required in a B-reading. Furthermore, the interpretations of Petitioner's B-readers were not consistent. Dr. Smith found the 2002 film to be positive for pneumoconiosis, category 1/1. He noted that same profusion on the films which were taken seven and almost eight years later. Dr. Alexander found the films from 2002 and 2010 to both be positive but noted a profusion of 1/0 on both films. Dr. Tazbaz testified that the diagnosis of coal workers' pneumoconiosis is generally considered an x-ray readings diagnosis. Without a positive x-ray reading, the diagnosis of coal workers' pneumoconiosis would not have been made. Dr. Tazbaz also diagnosed Petitioner with sleep apnea but testified that same had nothing to do with his coal mine work.

Dr. Korte issued a report to Petitioner's counsel stating that Petitioner had a history of findings of COPD which were caused or made worse by his exposures as a coal miner. After reviewing all of his office notes, Dr. Korte testified that he never diagnosed Petitioner with COPD, chronic bronchitis or coal workers' pneumoconiosis. Dr. Tazbaz testified that the results of the spirometry he performed on Petitioner revealed no obstructive defect. Dr. Selby testified that the resting spirometry that he performed on Petitioner was not valid. On Dr. Selby's testing Petitioner's lung volumes were normal. This testing eliminated the presence of an obstruction or restriction in Petitioner. Dr. Selby testified that a cough and spit daily for three months in a row

in two consecutive years fulfills the minimum requirements for a diagnosis of chronic bronchitis. Although Petitioner's medical records revealed some coughing at times, he failed to prove he met the criteria for chronic bronchitis.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner failed to prove by a preponderance of the evidence that he has an occupational disease arising out of and in the course of his employment and that his breathing complaints are causally related to his coal mine dust exposure. Petitioner has failed to prove that his current condition of ill-being is causally related to his employment with Respondent.

Issue (O): Other: Whether Petitioner proved timely disablement pursuant to Section 1(e) and 1(f) of the Occupational Diseases Act?

Petitioner testified that he first noticed breathing problems around age 55 when performing his mine managing duties. He testified that it was taking him longer to do things and he would get short of breath. He testified that from the time he noticed onset of breathing problems at the mine until he left the mine, the problems got worse. In his treatment at the VA from May 2008 to October 2012, Petitioner did not relate any shortness of breath, cough or sputum. Dr. Korte performed numerous physical examinations of Petitioner's chest and no abnormalities were revealed by of those examinations except for the lungs being positive for rhonchi on February 16, 2004. Petitioner provided a history to Dr. Korte of cough on occasions when he had sinusitis or upper respiratory infection. No treating physician related Petitioner's cough to his coal mine employment in their treatment records. When Petitioner saw Dr. Selby he really had no complaint about dyspnea on exertion or shortness of breath. Dr. Selby testified that Petitioner had the pulmonary capacity to perform any and all previous coal mine employment duties. Based upon the foregoing and the record taken as a whole, the Arbitrator finds that Petitioner failed to prove a timely disablement as defined in Section 1(e) of the Occupational Diseases Act.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Scott Locker,

Petitioner,

vs.

NO. 15 WC 23793

17IWCC0046

Mr. Bult's Inc.,

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, medical expenses, causal connection, prospective medical care, 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 May 6, 2016 is hereby affirmed and adopted.

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

No bond is required for the removal of this cause to the Circuit Court. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JAN 30 2017
SJM/sj
o-1/11/2017
44

Stephen J. Mathis

David L. Gore

Mario Basurto

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

LOCKER, SCOTT
Employee/Petitioner

Case# **15WC023793**

MR BULT'S INC
Employer/Respondent

17IWCC0046

On 5/6/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.39% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2028 RIDGE & DOWNES
JOHN E MITCHELL
415 N E JEFFERSON AVE
PEORIA, IL 61603

0560 WIEDNER & McAULIFFE LTD
JUSTIN SCHOOLEY
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

17IWCC0046

STATE OF ILLINOIS)
)SS.
COUNTY OF MC LEAN)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Scott Locker
Employee/Petitioner

Case # 15 WC 23793

v.

Consolidated cases: n/a

Mr. Bult's 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 William R. Gallagher, Arbitrator of the Commission, in the city of Bloomington , on March 30, 2016. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, July 30, 2015, Respondent was operating under and subject to the provisions of the Act.

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

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

In the year preceding the injury, Petitioner earned $72,800.00; the average weekly wage was $1,400.00.

On the date of accident, Petitioner was 46 years of age, married with 0 dependent child(ren).

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

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

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

ORDER

Based upon the Arbitrator's Conclusions of Law attached hereto, claim for compensation is denied.

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

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

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

William R. Gallagher, Arbitrator
ICArbDec19(b)

May 3, 2016
Date

MAY 6 - 2016

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged he sustained an accidental injury arising out of and in the course of his employment for Respondent on July 30, 2015. According to the Application, Petitioner was attacked by a co-worker and sustained injuries to the "MAW." (Arbitrator's Exhibit 2). This case was tried in a 19(b) proceeding and Petitioner sought an order for payment of temporary total disability benefits and medical bills. Respondent disputed liability on the basis of accident, notice and causal relationship (Arbitrator's Exhibit 1).

Petitioner began working for Respondent in July, 2013, and drove a semi-truck. Petitioner and other drivers that worked for Respondent hauled trash from one location to a landfill. At trial, Petitioner testified that there was an order in which the truck drivers were designated to pick up their loads of trash. The drivers that had higher seniority got to pick up their loads first and those drivers that had lesser amounts of seniority were supposed to get in line behind them.

On July 29, 2015, Petitioner had an argument with another employee, Tom Bartz, who also worked as a truck driver for Respondent. Petitioner testified that Bartz was not following the seniority rule regarding the picking up of the trash. Essentially, Bartz was cutting in front of Petitioner who had more seniority than he did.

The following day, July 30, 2015, the argument between Petitioner and Bartz continued. The argument became more intense and physical than it had been on the preceding day. There was no question that there was a physical altercation between Petitioner and Bartz on that date.

At trial, Petitioner testified that he could not recall exactly what happened when he and Bartz fought each other on July 30, 2015. He stated that when his wife took him to the ER later that same day that his lip required some stitches. He also stated that he had been seen and treated by a number of physicians, has undergone speech therapy, various diagnostic tests, psychological evaluations, etc.

When Petitioner was cross-examined, he was asked if he ever called Bartz a fat mother fucker or whether he had threatened to beat him up. Petitioner denied having made both of these statements; however, he did admit that he had some prior verbal confrontations with Bartz.

Ricky Washko testified on behalf of the Petitioner at trial. Washko was also employed by Respondent as a truck driver. On July 30, 2015, while he was in the process of cleaning windows in his truck, he heard Petitioner and Bartz yelling at each other. He then observed them standing face-to-face and cursing at one another. He stated that Bartz pushed Petitioner in the chest which caused Petitioner to trip over a small cooler/lunchbox that was on the ground. He then observed Petitioner fall and strike his head on the asphalt. Washko also stated that after Petitioner was on the ground Bartz struck him on the cheek.

On cross-examination, Washko stated that he was not present during the earlier confrontation that occurred between Petitioner and Bartz on July 29, 2015. Further, Washko agreed that he did not witness the initial portion of the argument between Petitioner and Bartz on July 30, 2015.

Doug Lautwien testified on behalf of the Respondent at trial. Lautwien was also a truck driver employed by Petitioner. Lautwien stated that he heard Petitioner called Bartz a "fat mother fucker" and a "piece of shit." He then observed Petitioner grab Bartz's shirt and then Bartz proceeded to put Petitioner down on the ground. He also observed Bartz strike Petitioner after the Petitioner was on the ground.

Tom Bartz also testified on behalf of the Respondent at trial. He stated that he was previously employed by Respondent as a truck driver, but that his employment was terminated because of the fight of July 30, 2015. Bartz confirmed that there was a verbal altercation between him and the Petitioner on July 29, 2015; however, he also stated that there was no physical contact between the two of them at that time.

Bartz testified that when he arrived at work on July 30, 2015, he walked past Petitioner's truck and Petitioner then proceeded to follow him. The two of them argued with one another, but Bartz kept walking, but Petitioner continued to follow him. Bartz stated that when he turned around, Petitioner was there and he proceeded to grab Bartz's shirt and raised his fist. Bartz then tackled Petitioner which caused Petitioner to fall to the ground. Bartz stated that he did not know that Petitioner had struck his head when he fell. Further, he denied that he struck Petitioner when Petitioner was on the ground.

On July 30, 2015, Petitioner was seen in the ER of St. James Hospital. When seen in the ER, Petitioner stated that he had been arguing with a co-worker but that he did not recall the details of exactly what had occurred. Petitioner had a laceration to his lower lip that required sutures and also underwent a CT scan of the brain. The CT scan of the brain revealed a subarachnoid hemorrhage in the left parietal area (Petitioner's Exhibit 1).

Petitioner subsequently sought medical treatment from a number of providers which included St. Joseph's Medical Center, Dr. Ann Stroink, Dr. John Dickinson, Dr. Edward Pegg, Dr. Naved Yousuf, Dr. Won Jhee, and two psychologists, Lia Draper and Amanda Ball (Petitioner's Exhibits 2 - 7).

At trial, Petitioner stated that his employment was terminated because of the fight of July 30, 2015, and that he has not been able to work since that time. Petitioner continues to complain of headaches, sleep disruption, problems remembering things, difficulties with activities of daily living, etc.

Conclusions of Law

In regard to disputed issue (C) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes that Petitioner did not sustain an accidental injury arising out of and in the course of his employment for Respondent on July 30, 2015.

In support of this conclusion the Arbitrator notes the following:

There was no question that the fight between Petitioner and Bartz arose out of a dispute between the two of them that was work-related, namely, whether Bartz had violated the seniority protocol for picking up trash.

Fights occurring as a result of disputes such as the preceding are generally compensable; however, injury sustained by an employee who is found to be the aggressor in such a fight are not compensable. Franklin v. Industrial Commission, 811 N.E.2d 684, 689 (Ill. 2004).

It is not always necessary for the one determined to be the aggressor in a fight to strike the first blow. There can be situations in which abusive and antagonistic words can cause a participant in a fight to be the "aggressor" even if he does not strike the first blow. Ford Motor Co. v. Industrial Commission, 399 N.E.2d 1280, 1282 (Ill. 1980).

Petitioner had no specific recollection as to all of the events that led up to the fight between him and Bartz and he denied calling Bartz names or threatening to beat him up. However, Petitioner did admit to having some prior verbal confrontations with Bartz.

Petitioner's witness, Washko, heard a portion of the argument between Petitioner and Bartz and observed Bartz push Petitioner. However, Washko did not see what had occurred prior to that time.

Respondent's witness, Lautwein, testified that he heard Petitioner call Bartz a "fat mother fucker" and a "piece of shit" and observed Petitioner grab Bartz's shirt. It was after Petitioner grabbed Bartz's shirt that Bartz pushed him to the ground. Lautwein also stated that he observed Bartz strike Petitioner after he was on the ground.

Bartz's testimony was consistent with the testimony of Lautwein with the exception of his denying that he had struck Petitioner when Petitioner was on the ground.

The Arbitrator finds that Petitioner was the aggressor because he used abusive and antagonistic words directed at Bartz as well as initiating the first physical contact between them.

In regard to disputed issues (E), (F), (J), (K) and (L) the Arbitrator makes no conclusions of law as these issues are rendered moot because of the Arbitrator's conclusion of law in disputed issue (C).

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Tashawn Peerman,

Petitioner,

vs. NO. 10WC 11563

Soapy Rides Detail Shop & and Dan Rutherford,
State Treasurer as Ex-Officio Custodian of the IWBF,

17IWCC0047

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 8, 2016 is hereby affirmed and adopted.

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

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 30 2017
SJM/sj
o-1/19/2017
44

Stephen J. Mathis

David L. Gore

Mario Basurto

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

PEERMAN, TASHAWN
Employee/Petitioner

Case# **10WC011563**

SOAPY RIDES DETAIL SHOP & IWBF
Employer/Respondent

17IWCC0047

On 6/8/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.43% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

0000 SOAPY RIDES DETAIL SHOP
4513 W HARRISON ST
CHICAGO, IL 60624

5462 ASSISTANT ATTORNEY GENERAL
MAGGIE TIMLIN
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

17IWCC0047

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

Tashawn Peerman
Employee/Petitioner

v.

Soapy Rides Detail Shop & IWBF
Employer/Respondent

Case # **10** WC **11563**

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 **Gary Gale**, Arbitrator of the Commission, in the city of **Chicago**, on **6/6/16**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **3/7/10**, Respondent ***was*** operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did not*** exist between Petitioner and Respondent.

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

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

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

In the year preceding the injury, Petitioner earned **$6,929 in 11 weeks**; the average weekly wage was **$629.91**.

On the date of accident, Petitioner was **29** years of age, ***single*** with **1** dependent children.

Petitioner ***has not*** received all reasonable and necessary medical services.

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

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

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

ORDER

Because the Arbitrator finds the Norwegian American Hospital records from the date of the assault to be more credible than the Petitioner's testimony 6 years and 3 months after the assault the Arbitrator finds no accident arising out of and in the course of employment, and all benefits are denied.

Because the Arbitrator finds that based on Px 7 the Petitioner was a sole proprietor no employer-employee relationship existed and 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

Date

JUN 8 - 2016

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

Milorad M. Novakovich,

Petitioner,

vs.

NO. 13 WC 16791

Southern Wine & Spirits of Illinois,

17IWCC0048

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 7, 2015 is hereby affirmed and adopted.

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

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

17IWCC0048

No bond 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 30 2017
SJM/sj
o-1/19/2017
44

Stephen J. Mathis

David L. Gore

Mario Basurto

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

NOVAKOVICH, MILORAD M
Employee/Petitioner

Case# **13WC016791**

SOUTHERN WINE & SPIRITS OF ILLINOIS
Employer/Respondent

17IWCC0048

On 12/7/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.41% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0311 KOSIN LAW OFFICE LTD
DAVID X KOSIN
134 N LASALLE ST SUITE 1340
CHICAGO, IL 60602

0481 MACIOROWSKI SACKMANN & ULRICH
ROBERT E MACIOROWSKI
105 W ADAMS ST SUITE 2200
CHICAGO, IL 60603

17IWCC0048

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

Milorad M. Novakovich
Employee/Petitioner

v.

Southern Wine & Spirits of Illinios
Employer/Respondent

Case # **13** WC **16791**

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 **Gerald Granada**, Arbitrator of the Commission, in the city of **New Lenox**, on **November 9, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **August 23, 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 **$46,800.00**; the average weekly wage was **$900.00**.

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

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

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

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

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

ORDER

Petitioner has failed to prove the issue of causation. Therefore, 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

12/4/15
Date

DEC 7 – 2015

FINDINGS OF FACT

17IWCC0048

This case involves a Petitioner who alleges an injury to his left leg due to a traumatic incident on August 23, 2012 while working for the Respondent. The issues in dispute are: 1) accident, 2) causation, 3) medical expenses, 4) TTD, and 5) nature and extent.

Petitioner works for the Respondent as a warehouseman. He has worked for Respondent since 2003. His duties include working on a stand-up picker which has a pallet and requires he wear a harness. The picker lets him and the pallet up and down to different places to pick the product to put on the skid. He is required to go back to what they call "racks," that have conveyors in them and require loading them from the ground to about seven feet up. Petitioner testified that he is picking cases of liquor that weigh about 45 pounds. In August of 2012, he was working four ten-hour days and would handle approximately 500 cases per day. While performing these duties, he is bending, turning, twisting, stretching, depending upon the size of the skid and where the product is located. Petitioner would grip the cases of liquor with two hands and then turn and twist to put the cases on the skid.

Petitioner testified that on August 23, 2012 he was working in the warehouse picking cases of alcohol for delivery. At approximately noon he was using a picker to move product from a skid to a rack. In doing so he twisted from right to left with his feet planted while lifting a 45 pound case of alcohol. The movement caused him to feel sharp pain in his left knee. He testified that he reported the incident to his supervisor, and the supervisor asked him if he wanted medical care, which he declined. He finished his shift and went home. He testified that this occurred on a Thursday, and that he was scheduled off Friday, Saturday and Sunday. He testified that when he did finish his shift, he noted more than usual pain and swelling.

Petitioner testified that prior to this incident, he had undergone a reconstructive procedure to his ACL, leaving him with two screws in his left knee in 1980. His primary care provider is Dr. Destani, whose records show that Petitioner continued to have complaints in his left knee following his surgery. On May 14, 2010, the Petitioner returned to Dr. Destani with complaints of left knee tenderness with crepitus. X-rays performed on May 14, 2010 showed definite knee joint fusion. He returned to Dr. Destani on August 5, 2011 and the examination, again, revealed left knee tenderness throughout, with crepitus. On September 16, 2011 Dr. Destani's examination again revealed left knee tenderness throughout, with crepitus. On August 3, 2012, some 20 days prior to the alleged occurrence Petitioner saw Dr. Destani and again the examination showed left knee tenderness throughout, with crepitus. On August 23, 2012, Petitioner called Dr. Destani to refill a prescription, but there is no mention any incident at work in Dr. Destani's records.

On August 27, 2012, the Petitioner went to Physicians Immediate Care and gave a history that on August 23, 2012, while transferring cases from the pallet onto a plate, feeling a very vague pain in his left lateral knee. He gave a history of the pain and swelling increasing over the last three days. He did give a history of an ACL repair in that knee. Examination revealed normal gait and posture. There was a normal McMurray test on the left, normal anterior posterior Drawer test of the left knee, normal patellofemoral grinding test of the left knee, normal apprehension test of the left knee, normal left knee range of motion, normal sensation in the left lower extremity, normal patellar and Achilles deep tendon reflexes on the left, no left knee weakness, ecchymosis or laceration on the skin. Examination did reveal joint effusion on the lateral aspect of the knee along with tenderness to palpation. The impression was left knee strain.

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The Petitioner testified that he returned to work with restrictions of no prolonged standing. He was driving a forklift at that point in time.

The Petitioner testified that he returned to Physicians Immediate Care on September 4, 2012, advising that his knee felt a little better. He testified that his knee would swell after working a few minutes. The records from Physicians Immediate Care for September 4, 2012 indicated that the Petitioner was about 80% back to baseline. He felt that he could do his normal work. Examination revealed no swelling. The impression was left knee sprain/strain, improving. He returned to Physicians Immediate Care on September 11, 2012 and gave a history of being able to tolerate his shift. He denied any locking or giving way. There was no evidence of weakness, normal range of motion, no swelling. The diagnosis remained the same. The Petitioner returned to Physicians Immediate Care on September 18, 2012. The Petitioner testified that at this point in time, he was doing full duty. Examination revealed no swelling, normal range of motion. Petitioner's last visit with Physicians Immediate Care was on October 2, 2012. At that visit, Petitioner indicated that he felt that physical therapy will not help at this point in time because he has a chronic problem with the knee from prior surgeries. Examination revealed no swelling. There was full range of motion and no swelling noted in Petitioner's knee.

The Petitioner was seen by Dr. Destani on November 2, 2012. Examination of his left knee revealed tenderness throughout with crepitus. This finding has not changed, pre- or post-injury. Dr. Destani referred the Petitioner to Dr. Hejna.

Dr. Hejna performed an examination on December 7, 2012. The Petitioner gave Dr. Hejna a history of the injury to his knee at work occurring in August of 2012. He indicated that he was working full duty and gave a history of the left knee ACL reconstruction in 1980. He advised the doctor that had intermittent discomfort in his knee over the years. He indicated to the doctor that the injury in question caused symptoms of a greater severity and duration. Physical examination revealed that the petitioner was 5'8" tall, and weighed 240 pounds. The doctor did find the long midline surgical scar. He did find crepitation with range of motion. The doctor did find tenderness and mild effusion. These are the same findings pre-injury that were found on the MRI and examination findings by Dr. Destani prior to the injury in question. He was concerned that the Petitioner may have a meniscal tear and ordered an MRI.

An MRI was performed on December 13, 2012 and revealed ACL reconstruction without evidence of internal derangement. There was no evidence of any acute finding or meniscal tear.

On December 18, 2012 Dr. Hejna noted the Petitioner's knee pain had improved, and that Petitioner was on light duty. He noted the MRI showed the prior ACL reconstructive surgery but no meniscal tear. Examination revealed the same joint tenderness and effusion. On January 11, 2013 Dr. Hejna saw Petitioner and his findings indicated mild effusion and mild crepitation.

On February 8, 2013, Dr. Hejna also saw Petitioner. The doctor felt, contrary to the MRI findings, that the Petitioner had a meniscal tear. The Petitioner, during Dr. Hejna's treatment, worked light duty. The Petitioner returned to Dr. Hejna on August 16, 2013, again with similar findings, indicating he wanted to proceed to surgery.

On August 26, 2013 Dr. Troy Karlsson saw the Petitioner at the request of the Respondent. Dr. Karlsson took a history of the Petitioner transferring cases from a skid to racks and in so doing, twisted when he felt pain in his knee. The doctor took a history of his prior ACL reconstructive surgery in 1980 and a history of his care and

treatment since. He solicited the Petitioner's subjective complaints and performed a physical examination, which revealed tenderness, negative McMurray sign, full extension. X-rays of the left knee showed the screws in the tibia and in the lateral femur consistent with a prior ACL. The MRI was reviewed and it showed no evidence of meniscal tear. He reviewed the records from Physicians Immediate Care and Dr. Hejna and noted the Petitioner was diagnosed with having mild osteoarthritis radiographically and definitely asymmetric with the left knee being greater than the right. He found that there was no single injury at work, simply symptoms while transferring cases. He indicated that the Petitioner's condition was that of osteoarthritis of the left knee with no evidence of a meniscal tear. He indicated that the Petitioner's ability to work light or full duty would depend upon the petitioner's pain level. He did not put the Petitioner on any restrictions for the alleged injury. He recommended that the Petitioner lose weight and consider injections for the osteoarthritis.

On October 31, 2013, Dr. Hejna performed arthroscopic surgery on Petitioner's left knee. The surgery did not reveal any evidence of a meniscal tear or an acute injury. On December 13, 2013, Dr. Hejna released Petitioner to light duty as of January 6, 2014. When the company would not take him back to work Petitioner went back to Dr. Hejna who released him to full duty. The Petitioner testified that when he returned to work, he was changed to days, meaning five days a week, 8:00 to 4:30 p.m. He testified that he had to handle fewer cases. The Petitioner ast saw Dr. Hejna on January 31, 2014. He testified that at that time he continued to note swelling and stiffness. The records from Dr. Hejna for January 31, 2014 showed that the Petitioner was back to baseline in terms of his symptoms, which he was having prior to his knee injury. At that time, Dr. Hejna noted that the Petitioner was doing well. There was no instability, no joint line tenderness, no effusion. The doctor felt that Petitioner could continue to work and was advised to return on an as-needed basis.

Dr. Karlsson testified via evidence deposition on November 10, 2014. After reviewing the Petitioner's history and the treating medical records, Dr. Karlsson testified that his diagnosis of Petitioner was mild osteoarthritis. He opined that there was no singular injury at work, simply symptoms noted while at work, transferring cases. He believed that the Petitioner's arthritis was not related to or aggravated by the transferring of cases. He further testified that there was no additional care and treatment related to the work injury and that the Petitioner did not need any work restrictions from the incident in question. Dr. Karlsson testified that he reviewed the operative report of October 31, 2013, and noted that there was nothing found at the time of surgery that would be related to a single injury or event in question. He noted that what was found was partial thickness, without any loose bodies, some loss of cartilage and not something that occurred with a singular event. He testified that what was found was not a traumatic lesion. He reviewed Dr. Hejna's opinion and agreed that there was degenerative joint disease prior to the occurrence in August of 2012. However, he disagreed with Dr. Hejna's opinion that the pre-existing osteoarthritis was aggravated - instead testifying that it was a natural progression of his osteoarthritis. He noted that there was no discrete structural problem identified which could be attributed specifically to the accident of August, 2012, and that the fibrous adhesions and chronic synovitis could not have been caused or aggravated by the incident in question. He explained that the Petitioner simply developed symptoms in his knee which he had intermittently before and was developing them and feeling them somewhat worse during one day at work without any specific injury or structural damage to the knee. Dr. Karlsson testified that if there was any aggravation of symptoms, it was temporary.

Dr. Hejna testified via evidence deposition on April 22, 2015. Dr. Hejna testified that Petitioner provided him a history of incident and prior medical treatment involving his left knee, consistent with his medical records. He diagnosed the Petitioner with a meniscal tear based on the mechanism of pivoting/twisting type of maneuver. He confirmed that the MRI he had ordered failed to disclose any evidence of a meniscal tear. Dr. Hejna confirmed that he put the Petitioner on restricted duty and prescribed physical therapy. He further testified that the Petitioner continued to complain and that he continued to believe the Petitioner had a meniscal tear. Dr.

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Hejna testified that he did perform surgery on Petitioner's left knee on October 31, 2013. That surgery revealed some scarring within the joint, which is referred to as arthrofibrosis, with some softening and roughening of the surface of the articular cartilage, or chondromalacia. There was no meniscal tear seen. He testified that did find synovial material which was inflamed. He testified that based upon a reasonable degree of medical and surgical certainty that the inflamed synovial material could be a source of his pain, but could not determine whether it was different compared to before the injury. He testified that there was no way to tell whether or not the adhesions found pre-existed his work accident of August, 2012 and that they could have been there all along. He testified that there was no way to tell if the adhesions were caused by the August, 2012 injury. He couldn't tell whether the adhesions accounted for his increased pain. He testified that he did release the Petitioner, full duty, beginning January 6, 2014 and that the Petitioner's knee was doing well and his symptom level had returned to what he was experiencing before the injury of August, 2012. He testified that he gave him no restrictions and advised him to return if he had any problems. He testified that the Petitioner had not returned since his last evaluation. He testified that the Petitioner, prior to the injury, had some degree of early degenerative joint disease. He testified that at the time of surgery he found no structural problems which would be attributed to the work incident of August, 2012. He testified that the fibrous adhesion, the chronic synovitis and the chondromalacia found following the surgery were not specifically caused by the incident. He testified that the Petitioner's incident did not exacerbate his chondromalacia but could have increased his synovitis which lead to increased pain. He had no opinion as to what affect, if any, the injury had on the fibrous adhesions.

Petitioner testified that as of the time of the hearing, he continues to notice swelling and stiffness in his left knee which he did not have before the accident in question. He does not take any pain medication for his knee. He also is earning more money in his current job with Respondent, than what he was earning before the alleged accident date.

CONCLUSIONS OF LAW

1. With regard to the issue of accident, the Arbitrator finds that the Petitioner has met his burden of proof. In support of this finding, the Arbitrator relies on the Petitioner's testimony and the medical evidence. Petitioner's testimony that he felt pain in his left knee when he pivoted while carrying a case of liquor is clearly supported by the medical records and no evidence was presented to rebut the Petitioner's account of what happened on that day. Based on the evidence presented, the Arbitrator concludes that the Petitioner proved he had an accident while working for the Respondent on August 23, 2012.

2. Regarding the issue of causation, the Arbitrator finds that the Petitioner has failed to meet his burden of proof. This finding is supported by the medical evidence, which failed to show that the Petitioner's condition of ill-being in his left knee was made worst or that his pre-existing knee condition for which he had a prior constructive surgery, was permanently aggravated or exacerbated as the result of his August 23, 2012 incident. The evidence presented by Petitioner on this issue relied on the testimony and opinions of Dr. Hejna, who could not say with much certainty that the Petitioner's left knee condition was caused by the August 23, 2012 incident. Dr. Hejna's opinions with regard to the question of whether the incident in question could have aggravated or exacerbated Petitioner's pre-existing knee condition was tenuous at best in light of the fact that his testimony at times denied the causal relationship or at best, could only posit a possibility of causality. To further erode the weight of Dr. Hejna's opinions was the fact that he initially diagnosed the Petitioner with a torn meniscus – which was not supported by the MRI. Because of the Petitioner's continued subjective complaints and notwithstanding the objective MRI results, Dr. Hejna stood behind his diagnosis of a torn meniscus and proceeded to surgery. The results of the arthroscopic surgery only validated what the MRI had previously indicated – that Petitioner did not suffer from a torn meniscus. This post-surgery finding all but eliminated any

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weight in Dr. Henjna's opinions regarding Petitioner's medical condition. Given these blatant facts from the Petitioner's own evidence, the Arbitrator is persuaded by the testimony of Dr. Karlsson, who testified with no uncertainty that the Petitioner's condition of ill-being in his left knee was a natural progression of his osteoarthritis and that there was no evidence that the Petitioner sustained any traumatic injury to his left knee. As such, the Arbitrator concludes that the Petitioner's condition of ill-being in his left knee is not causally related to the August 23, 2012 incident.

3. Based on the Arbitrator's findings with regard to the issue of causation, all other issues are rendered moot.

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

Jessica Wheaten,

Petitioner,

vs. NO. 15 WC 25803

State of Illinois/Murray Developmental Center,

Respondent.

17IWCC0049

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 medical expenses, causal connection, prospective medical care, choice of physicians, 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 May 18, 2016 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision.

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

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

Pursuant to §19(f)(1) of the Act, this Decision and Opinion on Review of a claim against the State of Illinois is not subject to judicial review.

DATED: JAN 30 2017
SJM/sj
o-1/5/2017
44

Stephen J. Mathis

Mario Basurto

David L. Gore

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

WHEATEN, JESSICA
Employee/Petitioner

Case# **15WC025803**

SOI/MURRAY DEVELOPMENTAL CENTER
Employer/Respondent

17IWCC0049

On 5/18/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.37% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

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

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

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

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

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

MAY 18 2016

DONALD A. HARRIS, Acting Secretary
Illinois Workers' Compensation Commission

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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)

JESSICA WHEATEN
Employee/Petitioner

v.

Case # **15** WC **25803**

Consolidated cases: _____

STATE OF ILLINOIS/MURRAY DEVELOPMENTAL CENTER
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 **Christina Hemenway**, Arbitrator of the Commission, in the city of **Mt. Vernon**, on **March 3, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

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FINDINGS

On the date of accident, **December 13, 2014**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$45,660.16**; the average weekly wage was **$878.08**.

On the date of accident, Petitioner was **38** 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 **$any benefits paid** for TTD, **$n/a** for TPD, **$n/a** for maintenance, and **$n/a** for other benefits, for a total credit of **$any benefits paid**.

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

ORDER

As explained in the Arbitration Decision, Petitioner's current condition of ill-being with regard to her lumbar and cervical spine is not causally related to her accident at work on December 13, 2014. Petitioner reached maximum medical improvement on November 9, 2015. All benefits after that date are denied.

Respondent shall pay reasonable and necessary medical services through November 9, 2015, except for those itemized in Arbitrator's Decision, pursuant to the medical fee schedule as provided in Sections 8(a) and 8.2 of the Act. Respondent shall receive credit for amounts paid, including those paid through its group medical plan, for which credit is allowed under Section 8(j) of the Act. Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit.

Petitioner exceeded her two choices of treating physicians. Treatment and testing by her third choice is denied.

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

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

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

Signature of Arbitrator

May 15, 2016
Date

ICArbDec19(b)

MAY 18 2016

17IWCC0049

STATE OF ILLINOIS)
) SS
COUNTY OF JEFFERSON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

JESSICA WHEATEN
Employee/Petitioner

v. Case #: 15 WC 25803

STATE OF ILLINOIS/MURRAY DEVELOPMENTAL CENTER
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

The parties stipulated that on December 13, 2014, Petitioner sustained an accident which arose out of and in the course of her employment with Respondent. The parties further stipulated that Respondent has paid a portion of the medical bills and that Respondent is entitled to a credit for bills previously paid, including those paid pursuant to Section 8(j), for which a credit will be given. The parties stipulated that Respondent paid temporary total disability for the period of December 14, 2014, through January 16, 2016. Petitioner claims she is entitled to ongoing disability benefits from January 17, 2016, through the date of hearing.

On the date of accident, Petitioner was 37 years of age, single, with three dependent children. She was employed as a Mental Health Technician II at Murray Developmental Center, and had been so employed since February 2008. On that date she was assisting a resident to the restroom when the resident bent over to pick up something on the floor. She was holding on to Petitioner's right arm, and when she bent down she pulled Petitioner down with her. Petitioner testified she felt a pinching, pulling sensation in her lower back when this happened. She continued working her shift through the day and evening, and her pain increasingly worsened.

Petitioner first sought treatment at Med Plus and was seen by Dr. Palm. Petitioner testified Med Plus is a chiropractic facility that also has medical doctors and therapists. Petitioner's attorney characterized this as an urgent care facility.

Petitioner testified she had reviewed all her medical records and that they were accurate representations of what she told physicians at the time she was in their office. She testified that prior to the accident of December 13, 2014, she had been working fully duty and was not missing time from work. She was not getting any treatment for low back pain, but did recall she had previously filed a worker's compensation claim for a mid-back injury three to five years ago.

Petitioner testified she treated with the providers at Med Plus for awhile and they tried to find the problem. She had chiropractic adjustments and physical therapy, and used a TENS unit and ice, all of which helped for a brief time. She underwent an MRI and was also referred to Dr. Ermis at Vigilant Pain Management. Dr. Ermis put her on a heavy dose of narcotics and also did spinal epidural injections. Petitioner testified the narcotics made her feel good at first, but as she continued to take them she felt she needed more just to take the pain away, so she took more. The injections and narcotics did not help her get better.

Petitioner testified that after treating with Dr. Ermis she saw Dr. Kovalsky, after she had a conversation with somebody from Respondent's workers' comp department about her case. She testified she did not know who Dr. Kovalsky was before she talked to the work comp department, or what city he practiced in. Dr. Kovalsky ordered an EMG and also requested another MRI because he felt the first MRI was poor quality. He also continued her medication. Petitioner testified by that point she did not feel the pain pills were working. She did not feel Dr. Kovalsky's treatment and recommendations were helping at all.

Petitioner testified she saw Dr. Gornet upon referral by Dr. Schatz at Med Plus, which Respondent disputed. Petitioner testified she actually got a letter, written and signed by Dr. Schatz, referring her to Dr. Gornet, which she took to Dr. Gornet. She originally called Dr. Schatz to ask him for the referral, and then went in to pick up the letter. There was no medical treatment or therapy given to her when she got the referral, and the only purpose for going to Med Plus that day was to get the referral letter.

Petitioner testified Dr. Gornet got another MRI and got her off all narcotic medication. Before seeing him she was taking Norco, Meloxicam, and Tizanidine. She testified getting off the narcotic medication was not easy and it took her a couple of months to do so. Going through this process, her body was extremely painful and tingly to touch and she went through a lot of depression. Petitioner testified she was now off all narcotic pain medication and been for awhile.

Petitioner testified she attended an examination at the request of Respondent, which lasted about an hour. The doctor went through her medical records, tested her reflexes, felt her back, and took her height and weight. He reviewed the diagnostic tests in her presence. He did not indicate she needed any medical treatment. Petitioner testified she cooperated with the exam.

Petitioner's last appointment with Dr. Gornet was February 8, 2016, at which time he recommended "a full work-up", including a discogram and MRI spectrum. The discogram was scheduled for March 22, 2016. Petitioner testified Dr. Gornet "had me go into this study to get an MRI spectrum", which she understood to be an MRI with color. Those are the only tests currently scheduled, and she is to follow up with Dr. Gornet after the tests, on April 14, 2016. She testified her goal in treating with Dr. Gornet is to be able to do the things she was once able to do, to go back to work, and to be able to enjoy life again. She has three teenage boys, all of whom were under the age of 18 at the time of her accident. The oldest son lives with her.

On cross-examination, Petitioner testified she was not currently working and had not worked since her accident on December 13, 2014. Prior to her accident she had never treated with Med Plus and did not have a family physician at that time. When she injured her middle

back a few years ago, she went to the emergency room and then had physical therapy at St. Mary's Hospital in Centralia. She testified she heard about Med Plus through a lady at work. She confirmed that prior to trial she reviewed the exhibit list and did not see listed the referral letter from Dr. Schatz that she testified about. She acknowledged that none of the treating records from Med Plus, from December 15, 2014, through February 13, 2015, contained a record generated by Dr. Schatz. She testified she was referred to the pain management clinic by Dr. Collins at Med Plus.

Petitioner acknowledged she reviewed Dr. Kovalsky's treating notes prior to trial, but she did not recall him telling her that he wasn't really sure what kind of injury she had. She acknowledged Dr. Kovalsky sent her for an EMG nerve conduction study, which was normal. She denied Dr. Kovalsky ever mentioned that he thought she had a low back strain, although she acknowledged seeing that in his records. She did not recall the last time she saw Dr. Kovalsky. She testified he did not refer her to Dr. Gornet.

Petitioner acknowledged she signed the Application for Adjustment of Claim on July 21, 2015. She acknowledged she reviewed the letter from Dr. Williams regarding the IME exam, and saw in there where it said she was referred to Dr. Gornet by her attorney, Thomas Rich. She denied, however, that Tom Rich referred her to Dr. Gornet. She admitted Dr. Williams asked her how she became a patient of Dr. Gornet's but that she did not remember exactly what she told him. She admitted that when she went to see Dr. Schatz to get the referral letter, she told him she wanted to see Dr. Gornet. She testified she learned of Dr. Gornet's name from a co-worker, Julia Russell. She did not recall returning to Dr. Kovalsky after August 12, 2015. She testified she had never taken any kind of pain medicine until she went to Med Plus, but did not recall whether or not she took pain medicine for the problem she had four or five years ago with regard to her middle back. Petitioner acknowledged Dr. Williams' report stated she could return to work, but testified she had not tried to return.

Petitioner testified she saw Dr. Gornet in November 2015, at which time he recommended a CT discogram, which was scheduled for March 22, 2016. She did not see Dr. Gornet between November and February, although his notes reflected she should return in six weeks, which would have been late December or early January. She will return to see him on April 14, 2016. Petitioner testified that if Dr. Gornet put her back to work full duty she would be willing to return to work, and that she would rather be at work than going through all this pain.

Following her accident, Petitioner presented for treatment at Med Plus on December 15, 2014. The Arbitrator notes at the outset that the records from Med Plus frequently have two or three notes for any given day of treatment. While the separate notes appear to be from different treaters within the clinic, it is difficult to ascertain who the individuals are, what their specialties are, and/or what their particular role was in the treatment. When summarizing these records, the Arbitrator references only the dates of service, and treats the different notes for each date as one.

On December 15, 2014, Petitioner presented with complaints of burning and pain in her low back that went down into her left leg, as well as stiffness throughout her neck, upper back, and lower back. She related she first noticed significant pain on December 13, 2014, while at work, after a double shift. She rated the pain at 8-9/10. She complained of occasional numbness

that radiated down her left leg to her knee, and standing, sitting, and laying down hurt. On examination, she had a greatly antalgic gait and decreased mobility, and was in obvious discomfort. There were x-rays taken of the cervical, thoracic, and lumbar spine; however, the Arbitrator notes that the copy of the report was very difficult to read. The Arbitrator further notes that there is no history of the incident at work, as later reported. Rather, the record references only that Petitioner had worked a double shift. PX3.

Petitioner began physical therapy at Med Plus on December 16, 2014. She reported low back pain and left lower extremity radiation at times, left worse than right. She was observed to be in acute distress with guarded mobility. It was noted that the mechanism of injury was increased pain after work shift on December 13, 2014. On December 17, 2014, Petitioner was examined and gave a history of low back pain off and on, worse after working a double shift. The pain was mainly in her left lower back and she was tender to palpation at bilateral SI joints. On December 19, 2014, Petitioner underwent a left SI injection, due to pain in her left low back and down her buttock. She reported the burning had decreased and the pain came less throughout the day. On December 22, 2014, she underwent a right SI injection. She reported she was feeling better, with less pain and less spasm. Her range of motion and mobility was improving. Petitioner followed up on December 23, 26, and 29, with noted improvement except after increasing activities at home. On December 30, 2014, Petitioner underwent a second left SI injection, and on December 31 she underwent a second right SI injection. On December 31 it was noted she rated her pain at 0/10, and that she was back on pain medication to control symptoms. She had a normal gait and was in no acute distress. PX3.

On January 2, 2015, Petitioner reported her pain was 0/10 and that she had no radiating pain. She had been doing her home exercise program without an increase in pain and reported she was pleased to have no pain that day and pleased with the progress made. On January 5 she complained of right low back pain more than left and rated her pain at 6/10. On January 7, 2015, Petitioner rated her pain as 5/10 but had no radiating pain. She underwent a third right SI joint injection. On January 9 she reported extreme pain of 8-9/10 with severe spasm. She had a trigger point injection due to muscle spasm and pain. She had a third left SI injection on January 12, and a second trigger point injection on January 14. On January 16, 2015, she reported her low back pain to be 5/10. She had a guarded gait and decreased range of motion. PX3.

Petitioner returned on January 19, 2015, and had continued low back pain at 6-7/10. She was tender to palpation at L3-4 and L4-5 bilaterally. She reported an increase in bilateral radicular pain over the weekend, secondary to doing housework and laundry. She followed up on January 21 and 23. On January 26 Petitioner underwent a third trigger point injection. She reported pain and spasm, mostly on the right paraspinals into the right buttock. On January 28 she reported decreased spasm and pain, but her range of motion was still guarded. She underwent a fourth trigger point injection on January 30, 2015. She had a slight increase in range of motion. PX3.

On February 2, 2015, Petitioner returned. It was noted she had some improvement with physical therapy and chiropractic care, but still had a moderate degree of pain. She had difficulty sitting and it caused numbness in her buttocks. She reported she was not taking as many pain pills. Another note from that same day states Petitioner was in significant low back pain and that

she had been improving, but rode in a car to Springfield over the weekend, which increased her pain. It was noted she had used ice and TENS unit, but the pain never went away. She complained of pain into the right buttock with numbness, but stated it did not go below the buttock. She related her social life had been on hold due to her pain, and that she would like to return to work and be able to enjoy time with her children. She expressed frustration that she could not enjoy life. Petitioner followed up on February 4, 6, 9, 10, 11, 13, 17, 19, and 20, 2015, and treatment included a fifth and sixth trigger point injection. She underwent an MRI on February 10, 2015, which revealed a minimal disc bulge at L5-S1. Her symptoms remained low back pain, varying in intensity. On February 20, 2015, it was noted Petitioner was being referred to Vigilant Pain Management for evaluation. PX3.

Petitioner was evaluated by Dr. Chad Ermis at Vigilant Pain Management on March 26, 2015. It was noted she was referred there by Dr. Collins. She gave a history of injuring her back while walking a patient who bent over, causing her to bend over as well. She complained of constant aching, burning, and stabbing pain in her low back, as well as burning and tingling pain radiating into her buttocks and posterior leg to her toes. It was noted treatment had included NSAIDs, muscle relaxers, and opiates. Examination revealed pain to palpation of her paraspinals and bilateral sciatic notch. Her gait was normal and her range of motion was decreased. Dr. Ermis's assessment was sacroiliitis, displacement of lumbar disc without myelopathy, lumbosacral spondylosis, and lumbago. He recommended continued home exercises and medications of Mobic, Tizanidine, and Norco. PX5

On April 23, 2015, Petitioner returned to Dr. Ermis. She stated her pain had improved, but her main concern continued to be pain in her low back that radiated down both legs, right worse than left, to her first toe. Her muscle spasms and swelling had improved. She had restarted home exercise but noted a pulling in her back again. Examination revealed pain at the sacral base bilaterally with positive straight leg raise and facet loading sign bilaterally. His assessment remained unchanged. He recommended a series of three epidural steroid injections at L5-S1, then possibly bilateral SI injections. Petitioner underwent the epidural steroid injections on May 5, May 18, and June 8, 2015. PX5.

On June 11, 2015, Petitioner presented to Dr. Don Kovalsky. She completed an intake form, on which she reported her chief complaint was "mild disc bulge L5/S1 pushing on nerves on both left and right side". She rated her pain as 7/10 and described it as sharp, throbbing, aching, stabbing, and burning. It was noted that the appointment was requested by "self". With Dr. Kovalsky she gave a consistent and accurate history of the accident and her treatment to date. She reported pain of 7-10/10 and also reported numbness and tingling in both legs. She indicated she had had depression for the past six months, since she got hurt, and admitted to smoking about one pack per day for about 15 years. On examination she had bilateral low back pain with no buttock pain. Lumbar palpation was normal, with no boney or soft tissue tenderness. Buttocks palpation was positive, as was sciatic notch and SI joint on the right. Her range of motion was decreased, with pain on flexion. Achilles reflex was decreased bilaterally and tension signs were abnormal bilaterally. The remainder of the exam was normal. The MRI of February 2015 was noted to be of poor quality and very grainy. Dr. Kovalsky noted that the MRI report stated there may be some slight bulging of the disc far laterally in the neural

foramen, but that he did not appreciate that on the images. Dr. Kovalsky's impression was bilateral lumbar radiculopathy and he recommended Prednisone and physical therapy. PX6.

On June 20, 2015, Petitioner presented to the emergency department at St. Mary's Good Samaritan Hospital with a complaint of allergic reaction to Prednisone. She reported she had begun taking the Prednisone eight days prior, and four days prior she began experiencing a variety of symptoms. The symptoms included skin redness, difficulty sleeping, diaphoresis, swollen feet, knee pain, increased heart rate, chest pain, and spots on her tongue. She called her doctor on that day and was told to stop taking the Prednisone and start taking Benadryl. She stated the symptoms continued to worsen and she began having chills, shaking, and swollen throat. She had been taking Norco but it was noted she had been out of her blood pressure medicine for several days so had not taken it. On examination, she was tearful, hyperventilating, and markedly depressed. Her physical examination was normal, including an ECG. She had marked improvement with normal blood pressure following antihypertensives, Ativan and pain medications. Impression was elevated blood pressure and pulse secondary to no medication compliance, anxiety, and pre-existing back pain with radiculopathy. PX7.

Petitioner returned to Dr. Kovalsky on June 24, 2015, and reported numbness in her feet and weakness in her legs. Dr. Kovalsky noted that Petitioner's examination was very inconsistent with any significant neuropathic findings. She had normal sensation, normal reflexes, and normal gross muscle strength. Straight leg raise was equivocal at 90 degrees, but reverse straight leg was negative, as was Valsalva test. Petitioner had minor pain over the SI joints but provocative testing did not aggravate the buttock or leg pain. Dr. Kovalsky noted, "I'm not sure at this point specifically what her injury is. It seems an inordinately long period of time for her to have these symptoms without improvement even just with tincture of time." He recommended an EMG nerve conduction study and possibly a repeat MRI and noted it was "not clear" to him why Petitioner was having pain. PX6.

Petitioner returned to Dr. Ermis on June 25, 2015, with continued complaints of low back pain with radiation into both legs, left worse than right, down the posterior leg to the lateral calf and to the first toe. She reported the pain had improved with the injections and it was not as intense as previously. She was able to tolerate more physical activity prior to the pain worsening. She reported she had seen Dr. Kovalsky regarding back surgery, who put her on Prednisone. Due to an adverse reaction, however, she discontinued it. Dr. Kovalsky recommended an EMG, and Dr. Ermis agreed it was a good idea. On examination, Petitioner was in no acute distress. Her strength was 5/5 bilaterally in both the upper and the lower extremities. She had decreased range of motion in the cervical and lumbar spine, and pain to palpation of the paraspinal muscles and lumbosacral junction. Assessment remained sacroiliitis, displacement of disc without myelopathy, lumbosacral spondylosis, and lumbago. PX5.

Petitioner began physical therapy on July 7, 2015. She had a total of twelve visits through August 3, 2015, with some relief of her symptoms, but not complete relief. PX7.

On July 23, 2015, Petitioner underwent EMG nerve conduction studies by Dr. Aiping Smith. She gave a history of low back pain with numbness, tingling, and weakness in both legs, left more than right. The EMG/NCS was deemed to be normal, without evidence of

radiculopathy of left L2 through S1 and right L4 through S1. There was also no evidence of peripheral nerve entrapment in the lower extremities. PX6.

Petitioner returned to Dr. Ermis at Vigilant Pain Management on August 4, 2015. She complained of worsening upper buttocks pain, previously improved following injections. She noted improvement in radicular pain but stated it had moved to her posterior thighs down to her knees. She reported that the pain medication was helping her get through physical therapy and that she had contacted an attorney. On examination, she was in no acute distress but did have decreased range of motion of the lumbar spine. Facet loading sign was positive, as was straight leg raise. She had bilateral pain to palpation of the lumbosacral junction and returning pain to palpation of the bilateral sacral base. Dr. Ermis's continued assessment was sacroiliitis, displacement of disc, lumbosacral spondylosis and lumbago. He recommended continued physical therapy to continue centralization of her pain and strengthening of her back. He continued her on Norco and Elavil. PX5.

On August 12, 2015, Petitioner returned to Dr. Kovalsky and reported continued low back and buttocks pain with some numbness and tingling in her legs. She indicated she had been in physical therapy and felt a little more functional, a little stronger and more limber. However, she stated she continued to have pain. It was noted the EMG showed no evidence of radiculitis and no denervation. Dr. Kovalsky reported he had no complete explanation for why Petitioner was having pain. On examination, Petitioner had significant pain with flexion about ten to twelve inches off the floor. She had some paralumbar muscle spasm in her lower lumbar region, with no bony tenderness. She had tenderness over both SI joints and provocative testing caused some pain in the SI joints. Dr. Kovalsky opined Petitioner may have SI joint dysfunction as the etiology of her pain. He recommended a new MRI, as he noted the previous MRI was very poor quality and it may be that he was missing something. He noted if there was a disc problem it would not necessarily show on an EMG and it could produce the referred pain in the buttocks and legs that Petitioner was experiencing. He recommended a new MRI and follow up with him a week or so following the MRI. PX6.

On September 21, 2015, Petitioner presented to Dr. Matthew Gornet of The Orthopedic Center of St. Louis. Dr. Gornet reported Petitioner had been referred to him by her chiropractor, Dr. Jeffrey Schatz. Her chief complaint was low back pain to both sides, both buttocks and hips, and down both legs to her feet, with pain into her right groin. She also complained of burning in her neck and upper back and related it to her original accident. She related that when the patient bent down while holding Petitioner's right arm, this was an unexpected movement and it pulled her suddenly. Dr. Gornet reported that, "During this activity, she feels she injured her back as well as her neck." She reported bilateral leg pain and paresthesias, right more than left, and noted symptoms were constant and worse with certain activities. She reported she had tried chiropractic care, Hydrocodone, six SI joint injections and three epidural steroid injections. She also reported attending physical therapy, which she did feel had benefited her. PX8, RX5.

On examination, Petitioner motioned she had pain in her low back and both buttocks and hips, particularly on the right side, right buttock, and right hip, and down both legs, particularly in the right groin. Range of motion of the hips was not productive for pain, nor was straight leg raising. Lumbar x-rays were normal. An MRI was done the day of the exam (PX9), which Dr.

Gornet interpreted as positive for a small central disc protrusion abutting up to the cauda at L45-5 and L5-S1, with a suggestion of an annular tear. PX8, RX5.

Dr. Gornet opined Petitioner had several issues, including a potential disc injury at L4-5, discogenic pain, and narcotic medication which had been significantly detrimental to her health. He did not believe Petitioner had an SI joint problem and his working diagnosis was discogenic pain at L4-5. He prescribed Meloxicam and renewed her prescription for Tizanidine. He discussed with Petitioner that she must choose which provider she would like to treat with, as his approach may be very different than someone else's. Dr. Gornet opined that Petitioner's current symptoms were causally connected to her work injury and he kept her off work. PX8, RX5.

On November 9, 2015, Petitioner was evaluated by Respondent's Section 12 examiner, Dr. Joseph Williams of the Orthopedic Center of Illinois. She provided a consistent history of the accident and her treatment to date. She complained of low back pain that radiated down both legs, right worse than left, with symptoms going all the way down on the left but not the right. She reported a sharp and tingly sensation on the anterior aspect of the right leg and into the groin, as well as numbness and tingly in both legs and feet. Petitioner reported she had been seen by Dr. Kovalsky, participated in physical therapy, and had an EMG. She further reported she was referred to Dr. Gornet by her attorney, Mr. Rich. Petitioner denied prior injuries to her lumbar spine and prior symptoms in her lower extremities. RX3.

On examination, Petitioner did not appear to be in any distress and did not grimace or appear to be in any pain. Her muscle strength was 5/5 in both lower extremities. However, Dr. Williams noted, "While testing...she did at times appear to have give away and like a ratchet type of effort. This did not appear to be related to pain. There was concern that this was due to her lack of effort at times or the possibility that she was attempting to demonstrate some type of weakness. However, with continued prompting she would display 5/5 muscle strength." Petitioner complained of pain with light palpation over the lumbar spine. Her gait was normal but she had "audible signs" with standing from a seated position and attempting to get up on the examination table. There was no atrophy, no pain with internal or external rotation of the lower extremities, and negative straight leg raise. RX3.

Dr. Williams noted the MRI of February 10, 2015, revealed mild multilevel degenerative changes, worse at L5-S1, along with a mild disc bulge at that level. There was no central canal stenosis, no lateral recess stenosis, and no neural foraminal stenosis. He further reviewed medical records from Med Plus, Vigilant Pain Management, and Dr. Kovalsky. RX3.

Based on the mechanism of injury as described, Dr. Williams opined that at most Petitioner could have sustained a strain of the lumbar spine, which he would expect would be very much self-limited. He noted Petitioner had mild degenerative changes in her lumbar spine, worse at L5-S1, she was battling obesity and was a chronic long-term smoker of one pack per day. He stated, "She is describing symptoms in the lower extremities that have not been backed up with any dysfunction on an EMG. She is not demonstrating any physical exam findings suggestive of weakness or impaired neurologic function. She is displaying physical exam findings that she is attempting to possibly suggest weakness that in fact is not present." Dr. Williams further noted that Petitioner's degenerative changes were in no way related to the

alleged injury, that they predate the injury, and that they were the result of her age, obesity, and tobacco use that is chronic. RX3.

Dr. Williams opined that the medical treatment to date had been reasonable, but questioned whether or not it was necessary. With regard to proposed medical treatment, Dr. Williams noted he did not have medical records from Dr. Gornet and was not aware of any recommendations he had made. However, Petitioner related that additional injections had not been recommended, that she was not participating in physical therapy, and that she was taking only Meloxicam and Tizanidine. Dr. Williams opined that further treatment was not necessary and that Petitioner was not a candidate for surgical intervention. Petitioner is a smoker and is struggling with obesity, and Dr. Williams opined that the pain in her lumbar spine would be better served with a weight loss regimen and cessation of smoking. He agreed she should avoid any use of narcotic medication, for fear of tolerance and dependency. He opined Petitioner should be on an active exercise regimen and should continue the exercises she learned in physical therapy. He went on to opine that "no surgical intervention should be in the least part entertained". Based on his interaction with Petitioner, his review of the medical records, Petitioner's response to some of the treatments rendered, her diagnostic studies, and her complaints, his prognosis was "very much guarded". He opined Petitioner's degenerative changes will continue to progress due to her obesity and use of tobacco products. Dr. Williams believed Petitioner could work with no restrictions, as there were no physical exam findings or radiographic studies that suggested she needed any restrictions. He placed Petitioner at maximum medical improvement. RX3.

Petitioner returned to Dr. Gornet on November 12, 2015. He noted she had been asked to wean off narcotics and had done so. It had only been two weeks, and Petitioner was in the phase where she was extremely painful. Dr. Gornet noted if she continued to be off narcotics for six weeks he would recommend an MRI spectroscopy and a CT discogram. Her exam was unchanged and Dr. Gornet's working diagnosis continued to be discogenic low back pain at potentially L4-5 and L5-S1, with small central disc lesions. Petitioner was to remain off work. She returned to Dr. Gornet on February 8, 2016. It was noted she had remained off the narcotics, and Dr. Gornet recommended the CT discogram and MRI spectroscopy at levels L3-4, L4-5, and L5-S1. Petitioner brought Dr. Williams' IME report to the examination and Dr. Gornet commented on his review of same. He agreed with Dr. Williams that a lumbar strain should be self-limiting by definition, but the fact that Petitioner had persistent symptoms meant her complaints were inconsistent with a lumbar strain. Dr. Gornet opined that the mechanism of action was more consistent with a disc injury, which would cause similar symptoms to what Petitioner described of back, buttock, bilateral hip, and bilateral leg pain into her groin. Given the fact that Petitioner had been very compliant with Dr. Gornet's recommendations, he recommended further analysis. Petitioner was to return after the testing. PX8.

Dr. Gornet testified by way of deposition on February 29, 2016. He is a Board Certified Orthopedic Surgeon, whose practice is devoted to spine surgery, particularly treating neck and low back pain. He sees about 100 to 120 patients a week and performs five to seven surgeries a week. A large portion of his time is devoted to research, clinical trials for low back or neck pain, and different types of analysis. He is an author, contributing editor, and lecturer. PX10.

Dr. Gornet testified consistent with his report, including the records he reviewed and Petitioner's history of accident and treatment. He testified she had been referred to him by Dr. Jeffrey Schatz, a chiropractor, and that he frequently gets referrals from chiropractors. On examination he did not detect any focal neurologic findings or neurological deficit. He testified that does not mean there is the absence of a problem, as the majority of musculoskeletal things orthopedic surgeons treat have no neurologic findings. It means whatever is impacting the spine is not causing a neurologic deficit. Dr. Gornet testified he reviewed Petitioner's x-rays, which showed no significant instability or evidence of fracture. He also reviewed Petitioner's MRI of September 21, 2015, and thought there was a small central disc protrusion abutting up to the cauda at L4-5 and L5-S1. There was also a suggestion of annular tear and so there was some disc pathology that was suggested. Dr. Gornet testified that the previous MRI of February 10, 2015, was of extremely poor quality, likely from a machine that was about ten years old. PX10.

Dr. Gornet testified that the spinal disc is not just an inert substance that either pinches a nerve or it doesn't. A disc bridges the bones in the spine to allow movements. We can load the disc and it gives somewhat of a shock-absorbing affect. The annulus is a tough ring that encircles the softer nucleus which allows the compression to occur, like a cylinder. The outer one-third of the ring has nerve fibers in it, so when the ring is injured you can develop significant pain, independent of whether there is a pinched nerve or not. PX10.

Dr. Gornet testified that in his review of Petitioner's x-rays and MRI he did not see any evidence of significant degeneration in her spine, which indicated that her problem was not an issue of preexisting degeneration. He opined that Petitioner may have had a sudden mechanical load placed on her spine and had an injury to the annulus. His opinion was she had a potential disc injury at L4-5, not an SI joint problem, and that it was related to her work injury of December 13, 2014. Dr. Gornet testified Petitioner also had neck pain, but that it was placed on hold because it was not the most significant issue for her. PX10.

Dr. Gornet testified that when he saw Petitioner on February 8, 2016, she had been compliant with his request to wean off narcotics, which is a very difficult thing to do. He checked the state website to make sure she had not had further prescriptions filled. Based on that, he recommended the CT discogram and MRI scan spectroscopy. At that same exam, he also "evaluated" the IME report from Dr. Williams. He noted Dr. Williams did not have medical records from his office at the time he saw Petitioner. He opined that Petitioner's symptoms were inconsistent with a lumbar strain, which was Dr. Williams' assessment, and that the mechanism was more consistent with a disc injury, which would cause similar symptoms to what Petitioner described. Dr. Gornet testified that given the fact that Petitioner had been compliant with his recommendations for narcotic weaning, he felt it was important to work her up. PX10.

Dr. Gornet testified that Petitioner is involved in an FDA clinical trial looking at both the CT discogram and the MRI scan spectroscopy. He explained that a discography fills the disc up with fluid inside the annulus. If the disc is intact, there is no leakage of dye and no painful response. If the disc is torn, leakage will be seen through the tear, which may or may not be painful. In some patients, the tears will be painful and it is associated with their typical back pain. Dr. Gornet explained that the MRI spectroscopy is a chemical biopsy of the disc. There are painful chemicals in the disc, independent of anything else, and they can be objectively

measured. With regard to Petitioner, Dr. Gornet testified he is looking at different factors, including objective annular injury, subjective pain, and objective pain chemicals, which will be put together to make his assessment. PX10.

Dr. Gornet testified that if Petitioner's tests are negative he would tell her he did not have any objective information to be consistent with her studies and she would be released back to work with no further treatment necessary. If she is found to have a tear, she would be treated conservatively. If that failed, she would be a candidate for either a fusion or a disc replacement, depending on the objective pathology. He opined that if he could isolate and define her problem, there is no reason Petitioner shouldn't do well, with or without surgery. She is not currently at maximum medical improvement because she has not been worked up appropriately, and she should remain off work. PX10.

On cross-examination, Dr. Gornet testified he gives about 100 depositions a year, but did not know how many of those are with Mr. Rich's office. He did not know when Petitioner became a client of Mr. Rich, in relation to when she first presented to his office for treatment. Dr. Gornet admitted that he was part owner of MRI Partners of Chesterfield, to which he sent Petitioner for an MRI on September 21, 2015. PX10.

Dr. Gornet acknowledged that Petitioner was 5'3" and weight 183 pounds, but denied knowing whether that fit into the classification as "obese". He further opined that there is no correlation between obesity and disc degeneration and was not sure if there was a correlation between self-reported low back pain and obesity. PX10.

Dr. Gornet testified that Petitioner complained of bilateral leg pain, which could be caused by an annular tear, and that her symptoms were fairly classic of a disc injury. He further opined that, "Whether or not that bears out to be correct, we just don't know. We have to work her up more fully." He opined that once you have an annular fissure or tear, it generally remains and will not mend itself. Some patients with an acute annular tear have horrible pain, and then it resolves. Other patients have persistent symptoms that need to be treated, beginning with targeted steroid injections in the area of the tear. Dr. Gornet's working diagnosis is a tear, but it needs to be confirmed by further testing. He testified that "lumbar strain" is not a differential diagnosis in this case, as Petitioner's symptoms are not consistent with that. PX10.

Regarding whether depression can make someone's mechanical back pain worse, Dr. Gornet testified he and others recently published a study on this. What they found in their study was that even with depression, patients improve with the appropriate surgery or treatment, but they just do not improve as much as the patients who have no depression before or after the surgery. Depression does not necessarily mitigate or change the fact that someone may have a structural problem. Dr. Gornet admitted that depression can cause symptom magnification with back pain, but also testified that a patient can become depressed if they have a structural injury to the spine that is not being diagnosed. PX10.

Dr. Gornet testified it is inappropriate to treat back pain with narcotic medication, which is why he required Petitioner to wean off of them and not go down the "wrong pathway". He opined that there is no study indicating chronic narcotics have any benefit for long-term back

pain, and that their use increases the chance of dependence, as well as the chance of disability. Dr. Gornet testified he did not return Petitioner to work because she had just come off the narcotics and no one had actually given her a diagnosis and told her what was wrong with her. He opined she needed further workup in that regard. PX10.

Dr. Gornet testified that annular tears cannot be caused by degenerations, but rather they are caused by mechanical loading of the disc that exceeds what the annulus can handle. Disc degeneration is a normal phenomenon that weakens the disc, and therefore mechanical loading produces more subsequent injuries to the degenerative disc than to a normal disc. PX10.

Dr. Gornet testified that he recommended to Petitioner that she quit smoking, but he did not believe her smoking will play a role in her overall symptoms. If Petitioner requires surgery, he may require her to quit smoking, depending on the type of surgery. If it is a microdiscectomy, he would like Petitioner to get to about a half a pack a day, as he does not see any increased complications at that rate over nonsmokers. He admitted that there is an increased degenerative disc disease associated with smoking. He was not aware of any correlation between body habitus and mechanical back pain. He has not recommended weight loss to Petitioner, but perhaps would, depending on the treatment recommendation. PX10.

Dr. Williams testified by way of deposition on March 1, 2016. He is a Board Certified Orthopedic Surgeon who treats orthopedic conditions. His focus is mainly on spine conditions, but also does some joint replacements. He treats individuals with cervical and lumbar spine conditions and treats both surgically and conservatively. He sees about one IME patient every two weeks. RX4.

Dr. Williams testified consistent with his report of November 9, 2015, including in regard to Petitioner's history to him, the medical records, and his examination. When asked about the quality of the MRI of February 10, 2015, which Dr. Kovalsky indicated was of poor quality and grainy, Dr. Williams testified he did not remember specifically the quality of the MRI. RX4.

Dr. Williams indicated that Petitioner complained of bilateral leg pain, going down to the foot on one side, which could be referred pain or radicular pain. Radicular pain is when there is pain in the low back but also nerve compression or irritation, and those nerves radiate down the lower extremities. To determine if there is nerve impingement, you look for sensation, changes in muscle strength, tension signs, or upper motor neuron findings. Dr. Williams testified that in his physical examination of Petitioner, he did not find any signs that were consistent with nerve impingement in the low back. During the examination Petitioner did not appear to be in any discomfort, she had a negative straight leg raise, and no loss of strength. RX4.

After taking a history from Petitioner, performing a physical examination, and reviewing the medical records, Dr. Williams opined that Petitioner had multilevel lumbar degenerative disc disease, worse at L5-S1. He believed she likely sustained a strain of her lumbar spine, and she was also battling obesity and history of tobacco use. Petitioner was five foot four inches, and weight 191 pounds, making her BMI 32. Dr. Williams testified that anything over 30 was considered obese. He further testified that there have been good studies that show there is an increased incidence of low back pain, increased incidence of degenerative changes, and

increased incidence of pain associated with the strains that obesity places on the disc spaces and the motion segments of the lumbar spine. Dr. Williams also testified that smoking directly and significantly affects the degenerative process within the lumbar spine, the oxidation of the discs, and overall degeneration. RX4.

Dr. Williams was asked to explain his comment in his report that Petitioner was "displaying physical exam findings that she is attempting to possibly suggest weakness that in fact is not present". He testified that he asks patients to provide resistance in an effort to evaluate strength, and that it is hard to fake weakness. When a patient provides a "ratchet type effort", it is an indication they are trying to perhaps not provide a good effort, or trying to throw off the exam. Such was the case with Petitioner. Dr. Williams testified that when prompted, Petitioner was able to give a good effort. RX4.

Dr. Williams testified he did not believe Petitioner had SI joint dysfunction. For that reason, he did not believe the SI joint injections she received were medically necessary. RX4.

Dr. Williams testified there is a correlation between increased symptoms, narcotic use, and depression with low back pain patients. He stated it was a vicious cycle, and that obesity, depression, chronic narcotic use, and low back pain were all tied together and affected one another. He testified that when patients wean off pain medication they have a rebound effect, with increased pain. When he saw Petitioner, she had weaned off the narcotic medication. RX4.

Dr. Williams testified he did not believe it was in Petitioner's best interest to have any surgical intervention. He opined she had reached maximum medical improvement and could work. RX4.

Dr. Williams was asked to explain what an annular fissure was. He testified it is often seen with the degenerative process. The annulus is a component of the disc, kind of like the outer lining of the disc. During the degenerative process the nucleus pulposis (the interior "jelly" of the disc) will degenerate and oxidize. As a result, the annulus will get cracks in the lining of it, resulting in fissures or tears. The fissures, he supposed, could be caused by trauma, but are most commonly seen in degeneration, or wear and tear. An individual with degeneration in the spine and annular fissures could still work full duty. Dr. Williams testified that the degenerative changes in Petitioner's spine predated her work accident. RX4.

On cross-examination, Dr. Williams was asked about his statement in his report that Petitioner was referred to Dr. Gornet by her attorney, Mr. Rich. Specifically, he was asked how he was aware of this if he did not have any of Dr. Gornet's records available for review. Dr. Williams testified that Petitioner herself told him this. RX4.

Dr. Williams acknowledged that Petitioner denied any prior injuries to her low back and that he was not provided any medical records documenting prior symptoms or treatment to her low back. Before this accident, Dr. Williams assumed Petitioner was working full duty. It was his understanding she had been off work and unable to work since the accident. Dr. Williams testified that he did not think Petitioner gave him a full effort during the examination in regards to her strength in the lower extremities. He agreed that Petitioner has stated her symptoms have

dramatically increased, but disagreed with her inability to work full duty. He opined he did not think Petitioner should have missed any time from work following the accident. Dr. Williams opined that Petitioner's diagnostic films reveal a fair amount of degeneration, consistent with a 38 year old smoker who is battling obesity. He admitted that the specific studies regarding obesity and its contribution to low back pain were not referenced in his report. RX4.

Dr. Williams acknowledged that he could not state for certain that he saw Petitioner's second MRI of September 21, 2015, taken at MRI Partners of Chesterfield. He further acknowledged that he did not know what Dr. Gornet's recommendations or opinions were in regard to this case. His diagnosis for Petitioner was a lumbar sprain/strain, which he would expect to have been symptomatic for two to three months before it resolved. Dr. Williams disagreed that conservative treatment had failed, but rather opined that treatment in general had been exhausted. He testified he did not necessarily agree that the patient is in the best position to give information about symptoms, and how they have progressed or changed, in that sometimes patients malinger or have secondary gain, and their interpretations are therefore in question. He opined that it was not out of the question that Petitioner was a malingerer. He did acknowledge that Petitioner had stopped taking narcotic medication, but did not know the extent of that. He agreed that was a difficult process for many patients to go through. RX4.

Dr. Williams testified that when he is treating an individual and formulating a treatment recommendation, he bases his recommendation on both the patient's symptoms and the results of an MRI. He agreed it can happen that someone's symptoms can be aggravated without an actual change in their pathology as seen on an MRI. Dr. Williams agreed that an annular tear can produce pain in the low back and referred pain into the legs, and that it could be acute in nature. He agreed that radiation into the buttocks and legs could be caused by something other than nerve root compression. RX4.

Dr. Williams testified he was familiar with a discogram but that he did not perform them in his practice. He did not think they are valid and opined they are very controversial. He explained that the discograms have to rely on the patient's subjective responses and the controversy is as to the interpretation and validity of the studies. He agreed that when you perform a discogram, you could possibly see dye leaking out of the disc. However, he opined that the mere fact that there is dye leaking out of the disc does not necessarily mean that is a pain generator. RX4.

He did not believe Petitioner had any SI joint dysfunction, and based on that he did not believe the SI joint injections were reasonable. Dr. Williams testified he is familiar with the practice of surgeons owning MRI facilities and is familiar with the literature that cautions against overuse of MRI's. The theory behind the literature is that if a physician has an interest in the MRI facility, there is some type of gain, and so there is a tendency to order the study more and to have a lower threshold for obtaining that study.

CONCLUSIONS OF LAW

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

The parties stipulated that Petitioner sustained an accident which arose out of and in the course of her employment on December 13, 2014, and that she injured her low back as a result.

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

A claimant has the burden of proving by a preponderance of the credible evidence all elements of the claim, including that any alleged state of ill-being was caused by a workplace accident. *Parro v. Industrial Commission*, 260 Ill.App.3d 551 (1993). Liability cannot be premised upon imagination, speculation, or conjecture but must arise from facts established by a preponderance of the evidence. *Illinois Bell Tel. Co. v. Industrial Comm'n*, 265 Ill. App.3d 681 (1st Dist. 1994).

The Arbitrator finds that Petitioner has failed to prove by a preponderance of the evidence that her current low back and neck conditions are causally related to her work accident of December 13, 2014. In so concluding, the Arbitrator finds significant the exhaustive treatment rendered by no less than four medical providers, the normal results of diagnostic testing, the opinions of two physicians regarding Petitioner's symptom magnification, and the Arbitrator's own observation and impression of Petitioner.

It is undisputed that Petitioner sustained a compensable accident which caused an injury to her low back. She sought medical attention within two days of the accident, with Med Plus. The Arbitrator does note, however, that the history reported by Petitioner to the various treaters at Med Plus did not contain a history of the accident as reported to her employer nine days after the accident. That history does not appear in any medical records until March 26, 2015, three months after the accident. Be that as it may, Petitioner treated with various individuals at Med Plus approximately every two days for more than two months. Treatment included six trigger point injections and three SI injections to each side. In addition, she underwent three epidural injections at L5-S1 at Vigilant Pain Management, upon referral by Med Plus.

Petitioner also treated with Dr. Kovalsky, who made four separate notations in his records regarding a lack of explanation of Petitioner's reported complaints. On June 24, 2015, Dr. Kovalsky noted Petitioner's examination was normal, and was very inconsistent with any significant neuropathic findings. He stated, "I'm not sure at this point specifically what her injury is. It seems an inordinately long period of time for her to have these symptoms without improvement even just with tincture of time." In an effort to give Petitioner the benefit of the doubt, and to attempt to discover the reason for her complaints, Dr. Kovalsky recommended an EMG nerve conduction study. He noted, however, that, "It's not clear to me why she's having pain. Again this is a Work Comp injury, and sometimes patients can have symptom

magnification or other issues that clearly would not be picked up on an imaging study. I think we owe it to make sure we are not missing anything before we just assume that there is (sic) psychosocial issues." The EMG/NCS, done on July 23, 2015, was completely normal, with no evidence of radiculopathy or peripheral nerve entrapment in the lower extremities.

On August 12, 2015, Dr. Kovalsky again made notations regarding the lack of explanation for Petitioner's reported complaints. He noted, "At this point I have no complete explanation for why she's having pain." He later stated, "Again at this point I don't have a specific diagnosis as to why she's having ongoing lower back pain."

In addition to Dr. Kovalsky, Dr. Williams as well had questions regarding Petitioner's veracity, given the lack of objective findings to support her complaints. He noted during the exam that he had concern about Petitioner's lack of effort during strength testing, which appeared to be an attempt to demonstrate some type of weakness. He stated, "She is displaying physical exam findings that she is attempting to possibly suggest weakness that in fact is not present." Dr. Williams also stated, "She is describing symptoms in the lower extremities that have not been backed up with any dysfunction on an EMG. She is not demonstrating any physical exam findings suggestive of weakness or impaired neurologic function." Based on the normal diagnostic testing, normal examination, and diagnosis of lumbar strain, Dr. Williams found Petitioner to be at MMI and in need of no additional medical treatment.

The only physician convinced there is an objective basis for Petitioner's subjective complaints is Dr. Gornet. Although all other providers found no such objective evidence that would explain Petitioner's complaints, Dr. Gornet wants to pursue additional testing and would have Respondent be liable for such testing. His records and testimony were that, because Petitioner had complied with his request to wean off narcotics, she should be given the benefit of the doubt and be "worked up". The Arbitrator does not find this to be a compelling reason to order Respondent to pay for additional testing, especially in light of the fact that Petitioner had already been fully "worked up", which revealed no objective findings. The Arbitrator further notes that the two tests Dr. Gornet wants approved, and which will have taken place by the date of this Decision, are tests which are currently in FDA clinical trials. Dr. Gornet put Petitioner into the study group for these trials. The fact that these tests are currently in clinical trials gives the Arbitrator pause, as there was no evidence submitted as to their efficacy. Respondent cannot be expected to pay for testing that is not well-established medical protocol.

The Arbitrator, through observation of Petitioner at trial and review of the evidence, finds Petitioner to be lacking in credibility with regard to the severity and extent of her pain, and the amount of disability resulting therefrom.

The Arbitrator does not find persuasive the opinions of Dr. Gornet with regard to Petitioner's lumbar and cervical spine, the need for additional testing and treatment, and the causation of same to her work accident. Rather, the Arbitrator is persuaded by Petitioner's treating records and Dr. Williams' opinion, and finds that Petitioner's current lumbar and cervical conditions and complaints are not causally related to her work accident of December 13,

2014. The Arbitrator finds that Petitioner was at maximum medical improvement on November 9, 2015, the date of the IME with Dr. Williams, though she was arguably at MMI on August 12, 2015, which was her final visit with Dr. Kovalsky

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

Under Section 8(a) of the Act, a claimant is entitled to recover reasonable medical expenses, the incurrence of which are causally related to an accident arising out of and in the course of her employment and which are necessary to diagnose, relieve, or cure the effects of the claimant's injury. *Absolute Cleaning/SVMBL v. Ill. Workers' Compensation Comm'n*, 409 Ill.App.3d 463 (4th Dist. 2011) (citing *University of Illinois v. Industrial Comm'n*, 232 Ill.App.3d 154 (1st Dist. 1992)).

Having found that Petitioner was at maximum medical improvement on November 9, 2015, the Arbitrator finds that Respondent is not liable for medical bills after that date. Specifically, and as explained in further detail under issue (O), Respondent is not liable for medical bills from Dr. Matthew Gornet/The Orthopedic Center of St. Louis or MRI Partners of Chesterfield. Exclusive of these providers, the Arbitrator finds that Respondent is liable for all other remaining bills as set forth in Petitioner's Exhibit 1, incurred through November 9, 2015, including bills related to the SI joint injections, which had been disputed. The Arbitrator finds these injections were reasonable to "diagnose, relieve, or cure" the effects of Petitioner's injury.

Subject to the medical fee schedule as provided in Sections 8(a) and 8.2 of the Act, the total of the medical bills awarded is as follows,: (1) Med Plus $11,061.00; (2) InMed Diagnostic Services $989.090; (3) Vigilant Pain Management $6,175.50; (4) Dr. Don Kovalsky $2,715.00; (5) St. Mary's Good Samaritan Hospital $6,371.00; and (6) Midwest Emergency Department Services $869.00. The parties stipulated and the Arbitrator finds that Respondent is entitled to a credit for medical benefits previously paid, including those paid through its group medical plan, for which credit is allowed under Section 8(j) of the Act.

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

In light of the Arbitrator's finding above with respect to issue (F), the Arbitrator finds that Petitioner is not entitled to ongoing medical care for her lumbar spine.

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

In light of the Arbitrator's finding above with respect to issue (F), the Arbitrator finds that Petitioner was entitled to temporary total disability benefits from December 14, 2014, through November 9, 2015. Respondent shall receive credit for all TTD paid to date.

In support of the Arbitrator's decisions relating to issue (O), whether Petitioner exceeded her two (2) choices of doctors, the Arbitrator finds the following:

Section 8(a) of the Workers' Compensation Act provides, in pertinent part, that the following medical providers are within a claimant's two choices of physician:

> (1) all first aid and emergency treatment; plus
> (2) all medical, surgical and hospital services provided by the physician, surgeon or hospital initially chosen by the employee or by any other physician, consultant, expert, institution or other provider of services recommended by said initial service provider or any subsequent provider of medical services in the chain of referrals from said initial service provider; plus
> (3) all medical, surgical and hospital services provided by any second physician, surgeon or hospital subsequently chosen by the employee or by any other physician, consultant, expert, institution or other provider of services recommended by said second service provider or any subsequent provider of medical services in the chain of referrals from said second service provider. Thereafter the employer shall select and pay for all necessary medical, surgical and hospital treatment and the employee may not select a provider of medical services at the employer's expense unless the employer agrees to such selection. At any time the employee may obtain any medical treatment he desires at his own expense. This paragraph shall not affect the duty to pay for rehabilitation referred to above. 820 ILCS 305/8(a).

The Arbitrator finds that Petitioner's treatment with Dr. Gornet constituted a third choice of physicians, and is therefore denied. In so concluding, the Arbitrator is persuaded by the medical records and by Petitioner's lack of credibility with regard to this issue.

It is undisputed that Med Plus was Petitioner's first choice, and it is further undisputed that Med Plus referred Petitioner to Vigil Pain Management and to InMed Diagnostics. The parties dispute whether Dr. Kovalsky was Petitioner's second choice, and further dispute whether Petitioner was referred to Dr. Gornet by Med Plus.

The Arbitrator finds that Dr. Kovalsky was Petitioner's second choice of treating physicians. Petitioner attempted to establish through her testimony that she was somehow referred to Dr. Kovalsky by Respondent. However, there is no evidence to substantiate what would appear to be a self-serving statement in that regard. Review of Dr. Kovalsky's records, specifically the "New Complaint History Form", in fact shows Petitioner herself requested the appointment. There is no indication that the appointment was made by or at the request of Respondent. Even if, arguendo, Petitioner obtained the name of Dr. Kovalsky from Respondent, such does not constitute a "referral" by Respondent. Petitioner argues that Respondent nonetheless "agreed to such selection" by Petitioner. Given that Petitioner is entitled to her choice of two physicians, Respondent

had no ability under Section 8(a) to challenge her change in treating physicians, nor was it necessary for Respondent to "agree" to her selection. The choice was Petitioner's.

Petitioner did not provide any corroborating evidence or testimony to establish a referral to Dr. Kovalsky by Respondent. The Arbitrator finds that Petitioner failed to prove by a preponderance of the evidence that her choice to treat with Dr. Kovalsky was anything other than her second choice of a treating physician pursuant to Section 8(a).

The determination as to whether a claimant obtained medical treatment as a result of a valid referral is a question of fact for the Commission. *Absolute Cleaning/SVMBL v. Ill. Workers' Comp Comm'n*, 409 Ill.App.3d 463, 468 (4th Dist. 2011) (citing *Nabisco Brands, Inc. v. Industrial Comm'n*, 266 Ill.App.3d 1103, 1108 (1st Dist. 1994)).

The Arbitrator finds that Petitioner exceeded her two choices of physicians, that Dr. Gornet was not a referral within the chain of referrals by Med Plus, and that Dr. Gornet was Petitioner's third choice of physicians. In so concluding, the Arbitrator finds compelling the lack of any notation or documentation within the certified records of Med Plus that such a referral was made.

Petitioner testified she called Med Plus and asked for a referral to Dr. Gornet, and that she physically went into the office and picked up a letter of referral, signed by a Dr. Schatz. However, the records of Med Plus are void of any indication that Dr. Schatz spoke with Petitioner, referred Petitioner to Dr. Gornet, examined Petitioner, or was ever involved in her care in any way. Petitioner admitted during testimony that the letter she referred to was not contained within the trial exhibit list or within the exhibits themselves. The Arbitrator notes, however, that other referrals made by Med Plus are clearly documented in the treating records submitted. Specifically, the referral to Vigilant Pain Management is noted in the office visit of February 20, 2015, and the referral to InMed Diagnostics for the MRI is noted in multiple office visits. Yet there was no notation in any record of the referral to Dr. Gornet.

In addition, Dr. Williams testified he specifically asked Petitioner how she came under the care of Dr. Gornet, to which she replied that she was referred by her attorney. Petitioner herself testified that the medical records in evidence were accurate representations of what she told physicians at the time she was in their office. Yet when asked about the aforementioned statement to Dr. Williams, she denied her attorney referred her to Dr. Gornet and she stated she didn't remember what she told Dr. Williams. The Arbitrator finds Petitioner lacking in credibility in regard to this issue.

The Arbitrator further finds compelling the lack of documentation within Dr. Gornet's records regarding a letter from Dr. Schatz. In his initial examination of Petitioner, and in his testimony, Dr. Gornet indicated Petitioner had been "referred by her chiropractor, Dr. Jeffrey Schatz", yet he made no mention of any letter and he produced no letter. Clearly, if such a letter existed, it would have behooved Petitioner to produce it at trial.

Given that such a letter was not produced, that the records of Med Plus contain no mention of a referral, and that Petitioner stated to Dr. Williams that she was referred by her attorney, the Arbitrator finds that Petitioner failed to prove by a preponderance of the evidence that she was referred to Dr. Gornet by Med Plus. As such, Dr. Gornet is Petitioner's third choice of physicians, contrary to Section 8(a). All treatment by Dr. Gornet, rendered or proposed, is hereby denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF PEORIA)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jackie Willis,

Petitioner,

vs.

NO. 14 WC 28719

Boesdorfer Trucking Co.,

Respondent.

17IWCC0050

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 29, 2016 is hereby affirmed and adopted.

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

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

17IWCC0050

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 30 2017
SJM/sj
o-1/5/2017
44

Stephen J. Mathis

Mario Basurto

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WILLIS, JACKIE [JACKIS WILLIS]
Employee/Petitioner

Case# **14WC028719**

17IWCC0050

BOESDORFER TRUCKING CO
Employer/Respondent

On 2/29/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

2217 SHAY & ASSOCIATES
SARAH R NOLL
1030 DURKIN DR
SPRINGFIELD, IL 62704

4476 KELLY LAW OFFICE
JAMES M KELLY
4801 N PROSPECT RD
PEORIA HTS, IL 61616

17IWCC0050

STATE OF ILLINOIS)
)SS.
COUNTY OF PEORIA)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Willis, Jackie [Jackie Willis]
Employee/Petitioner

v.

Boesdorfer Trucking Co.
Employer/Respondent

Case # 14 WC 28719

Consolidated cases: n/a

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Peoria, on January 21, 2016. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On April 1, 2014, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $47,184.00; the average weekly wage was $900.03.

On the date of accident, Petitioner was 58 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 $11,319.89 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $11,319.89.

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

ORDER

Respondent shall pay for reasonable and necessary medical services as identified in Petitioner's Exhibit 12, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule.

Respondent shall pay Petitioner temporary total disability benefits of $600.02 per week for 47 3/7 weeks, commencing April 2, 2014, through March 2, 2015, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $540.02 per week for 100 weeks because the injuries sustained caused the 20% loss of use of the person as a whole, as provided in Section 8(d)2 of the Act.

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

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

William R. Gallagher, Arbitrator

February 21, 2016
Date

FEB 29 2016

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged he sustained an accidental injury arising out of and in the course of his employment for Respondent on April 1, 2014. The Application alleged that while Petitioner was lifting an anhydrous ammonia loading arm that Petitioner sustained an injury to his "arm" and that the nature of the injury was a "bulging disc" (Arbitrator's Exhibit 2). Based upon the evidence tendered at trial, it was clear that Petitioner was, in fact, alleging an injury to his low back.

Respondent agreed that Petitioner sustained a work-related accident on April 1, 2014; however, Respondent disputed liability on the basis of causal relationship. In regard to temporary total disability benefits, Petitioner claimed that he was entitled to payment of temporary total disability benefits of 47 3/7 weeks, commencing April 2, 2014, through March 2, 2015. Respondent disputed liability for the period of temporary total disability benefits claimed by Petitioner, but alleged that Petitioner was entitled to temporary total disability benefits of 19 weeks, commencing April 2, 2014, through August 11, 2014 (Arbitrator's Exhibit 1).

Petitioner started working for Respondent in February, 1978, as a truck driver. Petitioner's job duties consisted primarily of hauling anhydrous ammonia in a liquid tanker. When Petitioner would load the anhydrous ammonia in the tanker, he would use a "loading arm" that Petitioner had to lift and maneuver into position, then attach the end of it to a fitting on the back of the tanker. At trial, Petitioner's counsel introduced into evidence photographs of the loading arm. A portion of the photographs were highlighted when Petitioner explained the process of lifting the loading arm and getting it into position (Petitioner's Exhibit 14).

Petitioner testified that on April 1, 2014, he grabbed the loading arm to lift and move it into position and, when he did so, he felt a sharp pain in his low back. At that time, Petitioner stated that the pain was not that severe and he continued to work. The following day, Petitioner's pain symptoms had worsened and he reported the accident to Kevin Montgomery, Respondent's Safety Director.

At the direction of Respondent, Petitioner was seen at Midwest Occupational Health Associates (MOHA) by Tonya Heim, a Nurse Practitioner, who diagnosed a lumbar sprain/strain. She imposed work/activity restrictions that included no commercial driving (Petitioner's Exhibit 1).

Because his symptoms worsened, Petitioner went to Memorial Express Care on April 5, 2014. At that time, Petitioner advised that he had hurt his back at work on Tuesday and had back pain that initially went down the left leg, but was now also going down the right leg. Petitioner was diagnosed with back pain and sciatica, prescribed some medications and directed to return to MOHA (Petitioner's Exhibit 2).

Petitioner was subsequently treated at MOHA during April, 2014. When seen on April 14, 2014, by Dr. Gregory Clem, Petitioner had received physical therapy, but Petitioner had no relief of his symptoms. Dr. Clem opined that Petitioner had a lumbar strain with right lower extremity radiculopathy. Dr. Clem ordered an MRI which was performed on April 16, 2014. According to

the radiologist, the MRI revealed multi level lumbar spondylosis and neural foraminal encroachment and a Grade 1 anterolisthesis of L4 on L5 (Petitioner's Exhibits 1 and 4).

Petitioner was subsequently seen by Dr. Koteswara Narla, a neurologist, on May 2, 2014. At that time, Petitioner advised Dr. Narla that he had sustained a twisting injury at work at the beginning of April, 2014. Dr. Narla noted that Petitioner had chronic lumbar pain and had been seen by a chiropractor, but that the last time was approximately one year prior. Dr. Narla gave Petitioner epidural steroid injections at the L4-L5 level on May 14, and May 28, 2014 (Petitioner's Exhibit 5). At trial, Petitioner testified that the injections did not help at all.

Petitioner was subsequently treated by Dr. Brian Russell, a neurosurgeon, who initially saw Petitioner on July 2, 2014. Dr. Russell's record of that date noted that Petitioner had sustained a lifting injury at work on April 1, 2014, and that he had back pain with radiation into both lower extremities, more in the right than left. Dr. Russell reviewed the MRI and opined that it revealed spinal stenosis, a "Grade 1 slip" as well as a disc herniation that compromised the L4 nerve root. Dr. Russell stated that if there was instability, fusion surgery with an interbody spacer or pedicle screws might be necessary (Petitioner's Exhibit 6).

At the direction of Respondent, Petitioner was examined by Dr. Morris Soriano, a neurosurgeon, on July 30, 2014. In connection with his evaluation of Petitioner, Dr. Soriano reviewed the MRI and medical records provided to him by Respondent. The medical records reviewed by Dr. Soriano included a record from Dr. Michael Gensler, a chiropractor, dated April 12, 2013, which noted that Petitioner had low back pain for approximately two weeks. Dr. Soriano also reviewed reports regarding surveillance of Petitioner conducted in May and June, 2014, but not the actual videos (Respondent's Exhibit 1).

Dr. Soriano opined that Petitioner sustained a lumbar strain with a history of chronic back pain and that Petitioner's complaints were not related to the accident of April 1, 2014. He also stated that Petitioner had positive Waddell signs and no objective findings on examination. In regard to surgery, Dr. Soriano opined that it was not warranted stating "I believe the chance of successful surgery in this gentleman and returning to work is extremely low." He also opined that Petitioner was at MMI in regard to the "alleged" lumbar strain of April 1, 2014 (Respondent's Exhibit 1).

Petitioner was again seen by Dr. Russell on August 29, 2014. At that time, Petitioner still had complaints of low back pain with pain going into both legs. Dr. Russell noted that Petitioner had been examined by an independent medical evaluator who opined that his condition was not work-related. Dr. Russell agreed that Petitioner had degenerative findings; however, he also noted that Petitioner's symptoms were worse after the lifting injury that occurred in April. He again noted that Petitioner had a spondylolisthesis at L4-L5 with a Grade 1, but probably almost a Grade 2. At that time, Petitioner decided that he wanted to proceed with the fusion surgery recommended by Dr. Russell (Petitioner's Exhibit 6).

On October 2, 2014, Dr. Russell performed surgery on Petitioner (assisted by Dr. Stephen Pineda, an orthopedic surgeon). The procedure consisted of a fusion from L4 to S1 with instrumentation (Petitioner's Exhibit 8). Following surgery, Petitioner continued to be treated by Dr. Russell who had Petitioner perform home exercises. Petitioner's leg pain had resolved when

he was seen by Dr. Russell on October 14, 2014. Dr. Russell authorized Petitioner to be off work and again instructed Petitioner to perform home exercises and gradually increase his level of activities (Petitioner's Exhibit 6).

Petitioner was able to return to work for Respondent on March 2, 2015. When seen by Dr. Russell on September 16, 2015, Petitioner did not have any significant radiating leg pain and the fusion hardware remained in place. At that time, Dr. Russell stated that he would only see Petitioner again on an as needed basis (Petitioner's Exhibit 6).

At trial, Petitioner testified that he had treatment for a back problem approximately 20 years ago. It was not clear whether this prior back problem was work-related; however, Petitioner stated that he had received an injection in his low back.

Petitioner stated that he was treated by a chiropractor prior to the accident of April 1, 2014, which he described as a "tune-up" so that he could play golf. However, Petitioner said that he had not received any chiropractic or other medical treatment for back symptoms immediately preceding the accident of April 1, 2014.

The treatment records of the chiropractor, Dr. Gensler, were received into evidence at trial. Dr. Gensler initially saw Petitioner on September 30, 2011, for low back pain. At that time, Petitioner noted that his pain was 6/10. Dr. Gensler continued to treat Petitioner in October and November, 2011, with some manipulation and application of heat. Petitioner was subsequently seen by Dr. Gensler on May 25 and June 1, 2012; however, most of Petitioner's complaints on those occasions were in regard to the cervical and thoracic levels of the spine. Petitioner was subsequently seen by Dr. Gensler on April 12, 2013, and complained of low back pain that had been present for about two weeks. Petitioner rated his level of pain as being 4/10. Petitioner again saw Dr. Gensler on April 24, 2013, and Petitioner's low back symptoms had improved to where he rated his pain level as being 1/10. Dr. Gensler opined that Petitioner's prognosis was "excellent" and stated that Petitioner was expected to recover "without residual complications." (Respondent's Exhibit 5).

Dr. Russell was deposed on February 13, 2015, and his deposition testimony was received into evidence at trial. In regard to his diagnosis and treatment of Petitioner, Dr. Russell's testimony was consistent with his medical records. In regard to his review of the MRI, Dr. Russell opined that it revealed a spinal stenosis and a Grade 2 spondylolisthesis at L4-L5. He opined that the spondylolisthesis pre-existed the accident of April 1, 2014, but that the accident caused Petitioner to become symptomatic with radiating leg pain thereafter. In explaining the basis for his opinion, Dr. Russell stated that Petitioner had a very narrow foramen so that there was not a lot of room for nerves making it easy for them to be irritated with bending, twisting and lifting (Petitioner's Exhibit 13; pp 11-12).

Dr. Russell testified that the surgery decompressed the nerves at L4-L5, removed the disc, put in a spacer and stabilized the spine by fusing it from L4 to the sacrum. He opined that the surgery was successful and that Petitioner did "very well" and Petitioner did not have any leg pain when he saw him on November 12, 2014. He opined Petitioner could return to work, but that he

needed to avoid heavy lifting which he described as being anything over 50 pounds (Petitioner's Exhibit 13; pp 19-23).

On cross-examination, Dr. Russell reaffirmed his opinion that the spondylolisthesis was a Grade 2 and that he disagreed with Dr. Narla's opinion that it was a Grade 1. He also admitted he did not have specific information as to the precise nature of Petitioner's job duties as a truck driver, namely, whether or not Petitioner had to load/unload the truck, how long he would spend driving, whether the truck had an automatic or manual transmission, etc. (Petitioner's Exhibit 13; pp 38-40, 47-48).

At Respondent's request, Dr. Soriano reviewed various x-rays, medical records and the transcript of Dr. Russell's deposition. He prepared a supplemental report dated June 11, 2015, wherein he stated that there was nothing in the preceding that would cause him to change any of his opinions as previously stated in his report of July 30, 2014 (Respondent's Exhibit 2).

Dr. Soriano was deposed on June 16, 2015, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Soriano's testimony was consistent with his medical reports and he reaffirmed his opinion that Petitioner's low back condition was a chronic condition and that Petitioner's complaints were not related to the accident of April 1, 2014. Dr. Soriano further opined that surgery was not reasonable based upon the symptoms, non-dermatomal findings and positive Waddell signs. He stated that these factors argued "...against any success of surgery." (Respondent's Exhibit 3; pp 18-22).

On cross-examination, Dr. Soriano was questioned about the reports of the video surveillance of Petitioner and he agreed that he had not actually reviewed the video itself. He conceded that the surveillance reports did not describe Petitioner carrying any heavy objects (Respondent's Exhibit 3; pp 52, 59).

Dr. Soriano acknowledged that he had been named as a Defendant in 15 to 20 medical malpractice suits. He was also questioned about various medical malpractice cases which had been settled. These included a settlement of $1,000,000.00 entered into in 2013, as well as a settlement of $650,000.00 entered into in August, 2006. In regard to the settlement of $650,000.00, Dr. Soriano testified that he did not recall if it was in connection with a spinal surgery and stated "I don't have that good of a memory." (Respondent's Exhibit 3; pp 46-48).

Respondent tendered into evidence video surveillance conducted in May and June, 2014. Counsel for Petitioner and Respondent reviewed the video and agreed that portions of it were not of Petitioner, but of one of his neighbors. Those portions of the video, while included in the video discs tendered into evidence, were excluded. In the admitted portion of the video, Petitioner was observed walking, getting in and out of his vehicle and carrying some bags of groceries (Respondent's Exhibit 4).

At trial, Petitioner testified that there was a significant difference between the back pain he had following the accident of April 1, 2014, and the pain that he had in the past. Further, Petitioner stated that the chiropractor had released him from care in April, 2013, and that he had not received any treatment for back symptoms until after the accident of April 1, 2014.

Petitioner described a successful surgical result and stated that 95% of the pain was gone and that he was able to perform all of his job duties. Petitioner stated that Dr. Russell imposed a 40 pound lifting restriction which has been honored by Respondent. Petitioner was still employed by Respondent as a truck driver at the time of trial.

Petitioner's wife, Sheila Sperry, testified on his behalf at trial. She acknowledged that Petitioner had some back problems prior to the accident of April 1, 2014; however, they were much more intense after the accident. Specifically, Sperry testified that when she took Petitioner to Memorial Express Care, Petitioner could barely move.

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, 2014.

In support of this conclusion the Arbitrator notes the following:

The fact that Petitioner sustained a work-related accident that caused him to experience pain in his low back and that it was reported the following day to Respondent was not disputed.

Petitioner had low back symptoms for which he sought chiropractic treatment prior to the accident of April 1, 2014. However, the last time Petitioner was seen by Dr. Gensler (the chiropractor who previously treated him) was on April 24, 2013, which was almost one year prior to the accident. At that time, most of Petitioner's low back symptoms had resolved and Petitioner rated his pain level as being 1/10. Further, Petitioner sought no further treatment for back symptoms until after the accident of April 1, 2014.

There was no dispute that Petitioner was able to work as a truck driver for Respondent prior to April 1, 2014, and that he was a long-term employee of Respondent having been hired in February, 1978. Petitioner was not disabled from work until after the accident of April 1, 2014.

Petitioner's treating physician, Dr. Russell, opined that Petitioner had spinal stenosis and a Grade 2 spondylolisthesis that pre-existed the accident of April 1, 2014, but that the accident caused Petitioner to become symptomatic.

The surgery performed by Dr. Russell resulted in an almost immediate resolution of Petitioner's bilateral leg symptoms. Petitioner stated that 95% of his pain symptoms were gone and he was able to successfully return to work to his job for Respondent.

The opinion of Respondent's Section 12 examiner, Dr. Soriano, that Petitioner's condition was a chronic condition that was not aggravated by the accident of April 1, 2014, was inconsistent with Petitioner's post accident symptoms and inability to work afterward as well as Dr. Russell's opinion regarding causality. Further, Dr. Soriano's opinion that the likelihood of a successful

surgical outcome and Petitioner's ability to return to work thereafter would be extremely low was clearly rebutted by the facts.

Further, Dr. Soriano's credibility is questionable. The fact that Dr. Soriano has been sued for medical malpractice and some of those cases have settled for significant amounts does not, in and of itself, mandate a conclusion that his testimony is not credible. However, when Dr. Soriano was deposed, he stated that he did not recall if a $650,000.00 settlement was for a spinal surgery and stated that he did not have "...that good of a memory." The Arbitrator finds it difficult to believe that Dr. Soriano would not have, at least, some recollection of a medical malpractice case that settled for $650,000.00.

The Arbitrator finds the opinion of Dr. Russell to be more credible and persuasive than that of Dr. Soriano.

The Arbitrator reviewed the video surveillance of Petitioner and finds it to be of little or no probative value.

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 12, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule.

In support of this conclusion the Arbitrator notes the following:

The Arbitrator's conclusion of law in disputed issue (F) and his finding that Dr. Russell's opinion regarding causality was more credible and persuasive than that of Dr. Soriano mandates this conclusion.

In regard to disputed issue (K) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes that Petitioner was temporarily totally disabled for 47 3/7 weeks, commencing April 2, 2014, through March 2, 2015.

In support of this conclusion the Arbitrator notes the following:

Petitioner was under active medical treatment and authorized to be off work during the aforestated period of time.

In regard to disputed issue (L) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes that Petitioner has sustained permanent partial disability to the extent of 20% loss of use of the person as a whole.

In support of this conclusion the Arbitrator notes the following:

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

Petitioner was a truck driver at the time of the accident and he had worked for Respondent in that capacity for approximately 36 years at the time he sustained the injury. Petitioner's testimony regarding the physical requirements of his job was unrebutted. The Arbitrator gives this factor moderate weight.

Petitioner was 58 years of age at the time of the accident. There was no evidence that Petitioner's age had any effect on the extent of disability. The Arbitrator gives this factor no weight.

There was no evidence that this injury will have any effect on Petitioner's future earning capacity. The Arbitrator gives this factor no weight.

The medical treatment records clearly indicated that Petitioner had spinal stenosis and spondylolisthesis at L4-L5 that pre-existed the accident of April 1, 2014, and that following the accident, Petitioner has significant low back and bilateral leg pain/symptoms. The condition ultimately required surgery that consisted of a fusion from L4 to the sacrum with instrumentation. Petitioner made a good recovery following surgery and was able to return to work to his job as a truck driver. The Arbitrator gives this factor significant weight.

William R. Gallagher, Arbitrator

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

ROBERT H. DAGGY JR.,

Petitioner,

17IWCC0051

vs.

No: 02 WC 46894

TRANSERVICE LEASE CORP.,

Respondent.

DECISION AND OPINION ON PETITION PURSUANT TO §§19(k) & 8(a)

This matter comes before the Commission on Petitioner's Petition for Review Pursuant to Sections 19(k)/8(a), of the Illinois Workers' Compensation Act. A hearing was held in Chicago on February 23, 2016 before Commissioner White. Respondent was represented by counsel, Petitioner appeared *pro se*, and a record was taken. As background, the underlying claim was settled by contract approved by the Commission on September 28, 2009. Pursuant to the contract, Petitioner received a settlement of $330,000.00 with open medical until Respondent funded a Medicare set-aside account ("MSA").

Findings of Fact and Conclusion of Law

1. Petitioner was allowed to testify in a narrative and conversational manner. He explained that he presented his Motion because he allegedly had continuing difficulty with Respondent's insurer authorizing and paying for medication prescribed by his doctor to treat his work-related condition of ill-being, Complex Regional Pain Syndrome ("CRPS"). He also alleged that he had to pay for his medication on numerous occasions, amounting to "a few thousand dollars a month."

2. On cross examination, Petitioner testified he was evaluated at the Rehabilitation Institute of Chicago ("RIC") on September 9, 2013, at Respondent's request. It was recommended that he be admitted to a detoxification program at Alexian Brothers. He acknowledged there was a conversation with an adjuster for Respondent in which admission to the program was offered. Petitioner also agreed that he refused to participate in an interdisciplinary pain management program at RIC. A detoxification program was also offered at the Rosmanoff detoxification program in Florida, but he did not know whether that was an approved treatment. However, he did not agree to participate in that program because "they don't deal with pain."

3. After cross, Petitioner explained that "the programs that they are suggesting do not do anything to help repair any damage to my arm. They are only programs when you give up trying to find some other treatment plan." Petitioner seemed to request a new spinal cord stimulator even though previous attempts failed. He indicated that treatment had been recommended by his doctor. Petitioner did not believe the treatments offered by Respondent were "medically necessary." He also expressed concern that participation in these programs may jeopardize certifications he received from USDOT that allow him to inspect trucks and allow him "to go into oil refineries, power plants, shipyards, boats."

4. Respondent's lawyer responded that after the claim was settled, it sent Petitioner to Dr. Konowitz, a pain specialist. He recommended detoxification because Petitioner's long-term use of opiate pain medication. A later evaluation at RIC also recommended such a program, in which Petitioner refused to participate. After a subsequent evaluation, Dr. Konowitz recommended Petitioner be prescribed only Xanax and Naprosyn, which were the medications that Respondent was currently authorizing. RIC also recommended against another spinal cord stimulator after three previous attempts had failed. Respondent's lawyer also noted that he was assured that attendance at the detoxification programs were not reported unless the attendance was due to psychiatric reasons and the patient applied for a FOID card. Therefore, Petitioner's licensures would not be endangered.

5. Petitioner submitted into evidence some reports from his treating doctor, Dr. Markiv of United Pain Services. On January 23, 2012, at Petitioner's request and in his presence, Dr. Markiv issued an open letter. He indicated he had a discussion with Petitioner about future pain management. He previously had stellate ganglion blocks, peripheral nerve blocks, Bier blocks, surgical tendon transfer, surgical nerve release, three unsuccessful spinal cord stimulator trials, and various combinations of narcotic-containing medications.

6. Dr. Markiv also noted that for the last year Petitioner was taking methadone, Oxycodone, Dilaudid, Opana, Cymbalta, Xanax, and topical agents. "Despite high dose narcotic-containing medication, pain intensity was still 4-6/10 depending on weather changes;" it was 8-9/10 without medication. Petitioner had been stable on the current drug regimen and Dr. Markiv recommended its continuation.

7. On June 5, 2014, Dr. Markiv noted that Petitioner reported no change and still had 6-7/10 pain with medication. The medication was helpful in reducing pain but not to the desirable degree. However, without medications the pain was unbearable. Petitioner denied abuse or addiction. Dr. Markiv refilled Petitioner's medications and they discussed interventional treatments including ganglion blocks, radiofrequency ablation, and a spinal cord stimulator to reduce dependence on narcotics. The next day, Dr. Markiv wrote a "note to the chart" indicating he was contacted by Dr. Trotter for peer review. Dr. Trotter suggested the dosage of narcotics be reduced to wean Petitioner off. Dr. Markiv noted that they had tried that previously but Petitioner had increased pain and the dosage was reinstated. Dr. Markiv also noted that the alternative was interventional procedures identified above. They agreed that Naproxen should be used intermittently.

8. On July 31, 2014, Petitioner reported average pain of 6-9/10. He wanted an increase of Xanax due to worsening anxiety. Dr. Markiv refilled medications and suggested a surgical consultation because of worsening pain.

9. On August 14, 2014, Dr. Markiv noted that he and Petitioner had been informed by Respondent's workers' compensation insurer that he should be weaned off narcotics and future treatment by the United Pain Services would not be covered. Dr. Markiv indicated that Petitioner was using medication sparingly and there was no history of misuse or abuse since he began treatment in around 2005. He continued the medications.

10. Thereafter, Petitioner continued to treat with Dr. Markiv. On numerous occasions Petitioner complained of 6-9/10 pain and Dr. Markiv continued to refill his prescriptions for narcotic pain medication. The last notation was on March 1, 2016. Petitioner again reported 6-9/10 pain and Dr. Markiv again continued the medications. They discussed the call Dr. Markiv received from a doctor at RIC. Dr. Markiv still recommended a spinal cord stimulator prior to reduction of narcotics.

11. Respondent submitted into evidence numerous doctor reports concerning Petitioner's condition and treatment. Among them were various reports from Dr. Konowitz. The first was dated April 12, 2013. Dr. Konowitz noted he was board certified in internal medicine, pain management, and anesthesiology. Petitioner reported his pain worsened after his tendon transfer. He treated thereafter with "postoperative posterior interosseous nerve dysfunction," multiple local injections, and medication. The medication helped the hand pain and the other treatment helped the forearm pain. He currently reported 4/10 pain rising to 8-9/10 with activity. His Beck Depression Score was 7.

12. Dr. Konowitz then answered interrogatories. His diagnosis was burning dysesthesias with residual sympathetic instability. Dr. Konowitz listed Petitioner's current medications. He opined that continuation of that drug regimen was ill-advised. Dr. Konowitz believed previous recommendations of "local Suboxone/Subutex treatment," or alternatively, referral to Romanoff Comprehensive Rehabilitation program in Florida, would be appropriate.

13. Respondent also introduced several reports from doctors at the Rehabilitation Institute of Chicago ("RIC"). On September 9, 2013, Petitioner presented to Dr. Atchison for a "comprehensive interdisciplinary evaluation." His total pain disability index was 40/70. Dr. Atkinson discussed with Petitioner the "principles of graded motor imagery and desensitization as treatments for the neuropathic pain which may be helpful in reducing his reliance on medications." Petitioner was not sure why he was being evaluated and believed his pain was currently reasonably under control. Dr. Atkinson explained Petitioner should consider alternatives to pharmacologic treatments.

14. On that day, Petitioner also presented to Patricia Cole for a psychological evaluation. Petitioner reported "continuing pain that has not responded to appropriate medical intervention." Ms. Cole diagnosed chronic pain syndrome. She thought "use of some maladjusted coping strategies, lack of some adaptive coping strategies, a low level of pain acceptance, and a high level of life stresses" were likely contributing to the pain problem. She concluded that Petitioner was a candidate for a chronic pain management program.

15. On September 11, 2013, Petitioner presented to Jennifer Barthel, CRC at RIC for a vocational rehabilitation evaluation. Petitioner had worked as a truck mechanic. He did not believe he could work in any job unless his pain was "fixed." Ms. Barthel noted that Petitioner seemed irritated with participation in the evaluation and that his workers' compensation and social security disability income "may be indicative of financial disincentive to return to work." Nevertheless, she deemed him "a fair candidate" for vocational services.

16. Dr. Konowitz examined Petitioner again and issued an addendum report dated April 4, 2014. Dr. Konowitz summarized all previous reports/addenda since his previous report. Dr. Konowitz' diagnosis was "CRPS treated with opioids. Patient is a Complex Type 2 Pain patient." As such Petitioner requires a multi-modality approach to pain control. Opioid treatment for CRPS was neither recommended nor appropriate. The current opioid program was detrimental and harmful. He agreed with the assessment by RIC. Petitioner's prognosis was poor unless he enrolled in the RIC program.

17. On June 27, 2014, Dr. Konowitz issued another addendum report. In answering a query, Dr. Konowitz explained that if Petitioner were placed in an inpatient program the weaning would be immediate. As an outpatient the weaning could occur over seven days and replaced with Butran and/or Suboxone and/or clonidine patch. Xanax and Naprosyn would be appropriate for up to a year.

18. On April 24, 2015, another RIC doctor, Dr. Calisoff, issued another report in which he noted that Petitioner met the Budapest criteria for CRPS. He also had chronic right hand/arm pain, mood/affect disturbance, sleep disorder, and continuous opioid dependence. Petitioner was interested in a "fix" for his pain including possible spinal cord stimulator or radiofrequency. He was not interested in learning techniques for coping with the pain.

19. As a doctor certified in pain/physical medicine/rehabilitation treatment, Dr. Calisoff opined that Petitioner should not have any additional interventional procedures, noting he failed three previous spinal cord trials. He also noted that Petitioner was taking an equivalent of 325 mg of morphine without significant pain relief, as well as smoking two packs of cigarettes a day. Dr. Calisoff recommended that Petitioner enter an inpatient detoxification program, such as that at Alexian Brothers, followed by ongoing counseling to address his mood. Dr. Calisoff did not believe he was a suitable candidate for the interdisciplinary pain program at RIC because he wanted a fix for his pain rather than strategies to cope with the pain.

20. On December 15, 2015, Dr. Calisoff issued an addendum in which he opined that no additional interventional procedures should be performed on Petitioner because he had not benefited from numerous previous procedures. He also opined that Petitioner would be best served by a detoxification program at Alexian Brothers for opiates and all controlled substance including Xanax, and thereafter a four-week inpatient interdisciplinary pain management program after completion of detoxification.

21. Dr. Calisoff issued another addendum on February 15, 2016 in which he stated that he did not agree with Dr. Markiv's recommendation for a fourth spinal cord stimulator trail because the first three did not work. He reiterated his recommendation for detox/pain management programs. Petitioner's intake of large doses of opiates was dangerous and potentially life-threatening. Petitioner reported taking OxyContin, Dilaudid, and Xanax daily. He had chronic hand/arm pain rated as 4/10 pain with medication and 7-8/10 without. Petitioner wanted to pursue additional interventional procedures.

The Commission is sympathetic to Petitioner's plight. It is certainly understandable that Petitioner wants a definitive treatment to completely relieve his condition and pain. Sometimes it is difficult to accept that even with the marvels of modern medicine, doctors do not have the ability to definitively treat and cure all conditions of ill-being. Unfortunately, that appears to be the situation here. Nevertheless, the Commission does not believe that Petitioner is necessarily in the best position to determine what medical treatment is in his best interest. Petitioner asked for one of three options, continuation of his current regime of narcotic pain medication, order Respondent to fund an MSA immediately, or order a fourth spinal cord stimulator. The Commission does not believe any of those options is currently viable.

The Commission is convinced that the continuation of high-dosage opioid pain medication is not in Petitioner's best interest. Every doctor, except the prescribing doctor, has specifically opined that the continuation of this regimen is not medically indicated but is dangerous and potentially life-threatening. Even Dr. Markiv indicated that he has tried to reduce Petitioner's dependency on opioid pain medication through reducing the dosage, but was unsuccessful. In addition, funding of the MSA would likely result in Petitioner using that fund to continue that regimen. While the Commission may not be able to stop Petitioner from obtaining prescribed narcotics on his own, the Commission does not believe it appropriate to sanction that continued dependency by officially facilitating that regimen through an award.

17IWCC0051

The Commission is persuaded by the opinion of Dr. Calisoff, an expert in pain/physical medicine/rehabilitation treatment at RIC. He opined that a fourth attempt to install a spinal cord stimulator would be counterproductive and that no medical intervention procedure of any kind was indicated at this time. Rather, he recommended an intense detoxification program followed by a multidisciplinary pain management program. Dr. Calisoff's recommendations were supported by the previous opinions of Dr. Konowitz and Dr. Atkinson. However, the Commission believes Petitioner should have a decision-making role into his prospective treatment. Such participation may provide Petitioner a better attitude toward the treatment, which is vital to success of such detoxification/multidisciplinary pain management programs. Therefore, the Commission orders Respondent to offer Petitioner more than one option for a qualified intense detoxification program and more than one option for a qualified intense multidisciplinary pain management program from which Petitioner may choose.

The Commission also concludes that Respondent acted reasonably in denying continued treatment with narcotic pain medication based on the opinions of Dr. Atkinson, Dr. Konowitz, and Dr. Calisoff. In addition, according to the record before us Petitioner has been offered the treatment recommended by Dr. Calisoff but has refused. Therefore, the Commission denies Petitioner's request under Section 8(a) to order Respondent to reimburse Petitioner for medications he obtained after Respondent denied additional narcotic medication or to assess penalties against Respondent for non-payment of medical expenses under Section 19(k).

IT IS THEREFORE ORDERED BY THE COMMISSION, that Petitioner's Petition for Review Pursuant to Sections 19(k)/8(a) for payment of current medical expenses and the imposition of penalties is hereby denied.

IT IS FURTHER ORDERED BY THE COMMISSION, that Respondent offer Petitioner more than one qualitied detoxification program and more than one qualified multidisciplinary pain management program from which he may choose.

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

DATED: JAN 31 2017

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

RWW/dw
O-1/18/17
46

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

Margaret Meyer,

Petitioner,

vs. NO: 08 WC 42329

17IWCC0052

Drury Inn,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, temporary 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 October 21, 2015, is hereby affirmed and adopted.

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

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

17IWCC0052

The party commencing 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 1 2017
TJT:yl
o 1/24/17
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MEYER, MARGARET
Employee/Petitioner

Case# **08WC042329**
09WC007081

DRURY INN
Employer/Respondent

17IWCC0052

On 10/21/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.11% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1157 DELANO LAW OFFICES LLC
PATRICK JAMES SMITH
1 S E OLD STATE CAPITAL PLZ
SPRINGFIELD, IL 62705

2396 KNAPP, OHL & GREEN
L DAVID GREEN
6100 CENTER GROVE RD
EDWARDSVILLE, IL 62025

17IWCC0052

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

Margaret Meyer
Employee/Petitioner

v.

Drury Inn
Employer/Respondent

Case # 08 WC 42329

Consolidated cases: 09 WC 07081

An *Application for Adjustment 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 Springfield, on August 21, 2015. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ 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 9, 2008, Respondent was operating under and subject to the provisions of the Act.

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

On this date, Petitioner did 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 $17,131.40; the average weekly wage was $329.45.

On the date of accident, Petitioner was 34 years of age, married with 4 dependent child(ren).

Petitioner has received all reasonable and necessary medical services.

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

Respondent shall be given a credit of $3,900.00 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $3,900.00.

Respondent is entitled to a credit of $513.20 under Section 8(j) of the Act.

ORDER

Respondent shall pay reasonable and necessary medical services provided to Petitioner on September 9, 2008, of $1,823.23 as identified in Petitioner's Exhibits 30, 42, and 51, as as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule. All other medical bills are denied.

Based upon the Arbitrator's conclusions of law attached hereto, all other compensation 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.

William R. Gallagher, Arbitrator

October 16, 2015
Date

OCT 21 2015

Findings of Fact

Petitioner filed two Applications for Adjustment of Claim which alleged she sustained accidental injuries arising out of and in the course of her employment for Respondent. In case number 08 WC 42329, the Application alleged Petitioner sustained an injury to her left shoulder on September 9, 2008. According to the Application, Petitioner was on the floor cleaning and, when she came up she hit a door knob which caused her to be thrown back down to the floor. In case number 09 WC 07081, the Application alleged Petitioner sustained an injury to her "Left shoulder, cervical, lumbar back and head" on December 31, 2008. According to the Application, Petitioner was walking out of the employees' restroom, slipped and fell hitting her head, back and shoulders (Petitioner's Exhibit 1). Respondent disputed liability in both cases on the basis of accident and causal relationship (Arbitrator's Exhibits 1 and 2). The two cases were previously consolidated for trial.

Petitioner began working for Respondent in March, 2008, as a housekeeper. At trial, Petitioner testified that she sustained a prior injury to her left shoulder; however, she stated that she had not received any medical treatment for that prior left shoulder injury since 1996. Petitioner testified that she had full use of her left shoulder when she began working for Respondent. Petitioner also stated that she had no prior neck or low back symptoms.

In regard to Petitioner's prior left shoulder injury, this was also a workers' compensation case which was settled for 67.5% loss of use of the left arm (Respondent's Exhibit 3). Petitioner testified that she had three surgical procedures performed in connection with that prior injury. When questioned whether she had multiple dislocations of her left shoulder prior to September, 2008, Petitioner stated that she could not remember.

Petitioner testified that she injured her left shoulder on September 9, 2008, [in the transcript the question was asked using the incorrect date of September 8, 2008] when her left shoulder struck a door knob as she was getting up after cleaning a floor. Following the accident, Petitioner was seen in the ER of St. John's Hospital. According to the ER records, Petitioner's left shoulder struck a "drawer" and was dislocated. The record also noted that Petitioner had a history of dislocated shoulders in the past and had undergone several surgeries. X-rays were obtained which revealed no evidence of a dislocation. The diagnostic impression was stated as "Dislocated left shoulder with spontaneous reduction." (Petitioner's Exhibit 6).

On September 15, 2008, Petitioner was seen by Dr. Mark Greatting, an orthopedic surgeon, who previously treated Petitioner for left shoulder dislocations. Dr. Greatting's record of that date noted that he performed left shoulder surgery on Petitioner in 1993 and Petitioner subsequently had two more left shoulder surgeries performed in 1996 by Dr. Post in Chicago. Petitioner informed Dr. Greatting that it had been many years since her shoulder had become dislocated. On examination, Dr. Greatting noted that the shoulder was stable and that it was unknown for sure if and when the shoulder actually dislocated. He authorized Petitioner to be off work and ordered physical therapy (Petitioner's Exhibit 6).

On September 23, 2008, Petitioner went to the ER of St. John's Hospital because of left shoulder pain. The ER record stated that Petitioner was sitting at a desk and her left shoulder "seemed to

dislocate." The record also noted that Petitioner had undergone surgery and had been there in the past when the shoulder was dislocated and spontaneously reduced. Again, the diagnostic impression was "Dislocated left shoulder with spontaneous reduction." (Petitioner's Exhibit 6).

Petitioner began physical therapy on October 1, 2008. At that time, Petitioner informed the therapist of the work-related injury of September 9, 2008, as well as the three prior left shoulder surgeries. In that regard, Petitioner advised that the three surgeries were performed because of her having dislocations of her left shoulder (Petitioner's Exhibit 4).

In the physical therapy record of October 16, 2008, it stated that Petitioner was at a restaurant the night before and when she attempted to empty her plate into a to-go box, the left shoulder went out of its socket and back in. The record also stated that Petitioner was going to see her family doctor about her neck and back because she had sustained a fall at IHOP on a wet floor and injured herself (Petitioner's Exhibit 4).

In the physical therapy record of October 23, 2008, the record stated that Petitioner's left shoulder symptoms had been getting worse since "falling at IHOP on 9/23/08." (Petitioner's Exhibit 4). Petitioner was subsequently evaluated by Dr. Jay Riseman, her family physician, on October 27, 2008, for left shoulder and low back pain. This record noted that Petitioner fell at IHOP on October 23, 2008 (Respondent's Exhibit 12).

At trial, when Petitioner was questioned about the fall she sustained at IHOP, she was uncertain as to exactly when it occurred but that it was sometime after September 9, 2008, but before December 31, 2008. Petitioner testified she was going into the bathroom and slipped and fell on her butt. When questioned if she dislocated her left shoulder as a result of this fall, Petitioner stated that she could not recall.

Petitioner had a CT/arthrogram of the left shoulder performed on November 3, 2008. Dr. Greatting saw Petitioner on November 10, 2008, and reviewed the diagnostic study. He opined that it revealed a partial thickness rotator cuff tear and that one of the suture anchors from her previous surgical procedures was out of the bone in the area of the greater tuberosity. He recommended arthroscopic surgery with possible rotator cuff repair and removal of the suture anchor or possible anterior labral repair/stabilization. Dr. Greatting released Petitioner to return to work with restrictions effective December 23, 2008 (Petitioner's Exhibit 4).

In regard to the accident of December 31, 2008, Petitioner testified that she was working light duty and was walking out of an employee bathroom which was adjacent to the laundry room. Petitioner testified that she sustained a slip and fall at that time.

Following the accident of December 31, 2008, Petitioner was taken to the ER of Memorial Medical Center. According to the ER record, Petitioner stated that she was unsure whether she passed out and may have "slipped on detergent." Petitioner was diagnosed with neck and back pain and instructed to see her family physician (Petitioner's Exhibit 2).

At trial, Petitioner said nothing about slipping and falling because of detergent or any other foreign material being on the floor. In regard to the accident of December 31, 2008, three

witnesses testified on behalf of the Respondent. Two of the witnesses testified live at trial and the other was deposed and said deposition was received into evidence at trial.

Flora Coffey was deposed on March 14, 2013, and her deposition testimony was received into evidence at trial. Coffey is retired but was a housekeeper for Respondent during the time Petitioner was employed there. On December 31, 2008, Coffey was folding laundry when Petitioner went to the bathroom. She found Petitioner on the bathroom floor lying on her back. Coffey testified that there was nothing on the floor where Petitioner fell including Tide or any other detergent. She stated that Petitioner complained of left shoulder pain at that time (Respondent's Exhibit 8; pp 9-17).

Ellie Lansing testified at trial. At the time of the accident of December 31, 2008, Lansing was the Assistant Manager. Lansing no longer works for Respondent because she returned to school to become an RN. Lansing testified that she received a telephone call about the accident and went to the location shortly afterward. She stated that she did not see any foreign material including Tide or detergent on the floor where Petitioner fell.

Bobbie Haley testified at trial. Haley has worked for Respondent for 25 years and is the Maintenance Engineer. He also received a call that there had been an accident in the laundry room on December 31, 2008. When he arrived at the scene of the accident, Haley observed Petitioner lying on the floor and stated that there was nothing on the floor where Petitioner fell, nor did he observe anything on Petitioner's clothing or shoes which could have caused her to fall. He also testified that it was not necessary for him to clean the floor afterwards.

Petitioner was seen by Dr. Greatting on January 13, 2009. According to his record of that date, on December 31, Petitioner went to the bathroom, washed her hands and was unaware that Tide had been spilled on the floor. Petitioner slipped on the Tide and remembered waking up on the floor and people over her asking if she was okay. Dr. Greatting's record of that date also noted that "She does not remember actually falling at work which is concerning to me." Dr. Greatting opined Petitioner sustained a bruise of the left shoulder and elbow. He authorized Petitioner to be off work and ordered physical therapy (Petitioner's Exhibit 4).

On January 16, 2009, Petitioner was evaluated by Dr. Cecile Becker, for recurrent falls/blackouts. According to Dr. Becker's record of that date, Petitioner informed her that she fell on December 31, 2008. Petitioner stated that "...she was coming out of the bathroom and the next thing she remembers she was laying on the floor looking upwards." Dr. Becker suspected that Petitioner may have had a seizure so she ordered an EEG. This was performed on January 21, 2009, and was normal (Respondent's Exhibit 13).

Petitioner received physical therapy and, when seen by Dr. Greatting on January 28, 2009, he released Petitioner to return to work without restrictions effective February 9, 2009. When Dr. Greatting saw Petitioner on March 3, 2009, he noted that Petitioner was scheduled for arthroscopic surgery on March 20, 2009 (Petitioner's Exhibit 4).

Petitioner began working for Springfield Clinic on March 5, 2009, as a Medical Assistant. At that time, Petitioner was still receiving temporary total disability benefits. At trial, Petitioner

testified that she did not believe that her continued receipt of temporary total disability benefits was improper.

Dr. Greatting performed arthroscopic surgery on Petitioner's left shoulder on March 20, 2009. The procedure consisted of removal of an intra-articular loose body, subacromial decompression and mini rotator cuff repair (Petitioner's Exhibit 4).

Subsequent to the surgery, Petitioner returned to work for Springfield Clinic on March 26, 2009, and worked 61.75 hours between that date and April 8, 2009 (Respondent's Exhibit 6). Petitioner was continuing to draw temporary total disability benefits during that period of time.

Petitioner was evaluated Midwest Occupational Health Associates (MOHA) on April 30, 2009, for an injury she sustained at Springfield Clinic on April 28, 2009. Petitioner stated that she slipped on some urine on the bathroom floor and fell striking her left elbow on a toilet paper holder and landed on her buttock. Petitioner was diagnosed with a left elbow contusion and lumbar spine contusion. Petitioner was authorized to continue to work full duty (Respondent's Exhibit 13).

On August 12, 2009, Petitioner was evaluated by Dr. William Payne, an orthopedic surgeon, for neck and low back pain. He diagnosed lumbago and cervicalgia and ordered physical therapy. Petitioner received physical therapy for her low back and neck from September 8 through September 29, 2009 (Petitioner's Exhibits 8 and 10).

On September 4, 2009, Petitioner was evaluated by Dr. Kotswara Narla, a neurologist, for her low back and neck pain. In regard to the accident of December 31, 2008, Petitioner informed Dr. Narla she fell at work and remembered waking up on the floor and that they thought she fell on a wet floor. Petitioner also advised Dr. Narla that she had not worked since the fall. Dr. Narla opined that Petitioner had cervical pain with bilateral shoulder radiation and lumbar back pain with bilateral leg radiation. He recommended further diagnostic studies (Petitioner's Exhibit 11).

Dr. Greatting saw Petitioner on September 17, 2009, and he imposed permanent work/activity restrictions in regard to Petitioner's left shoulder. Specifically, Dr. Greatting opined that Petitioner was not to lift more than 10 pounds with her left arm, not to lift more than 10 pounds at waist level, not to lift more than five pounds above the waist to the shoulder level and not to lift more than two pounds above shoulder level (Petitioner's Exhibit 4).

At the direction of Respondent, Petitioner was examined by Dr. Frank Petkovich, an orthopedic surgeon, on March 24, 2010. Dr. Petkovich was deposed on September 30, 2010, and his deposition testimony was received into evidence at trial. Dr. Petkovich testified that he examined Petitioner in regard to both accidents and he reviewed medical records and diagnostic studies that were provided to him. In regard to the accident of September 9, 2008, Dr. Petkovich opined that Petitioner sustained a left shoulder contusion as a result of that accident. Dr. Petkovich further opined that the left shoulder surgery of March 20, 2009, was not related to the September 9, 2008, work injury because all of the operative findings were for chronic changes inconsistent with an acute injury. Further, Dr. Petkovich opined that Petitioner could perform the same work that she was performing prior to September 9, 2008, but that she should have had some

restrictions at that time because she had previously undergone three surgical procedures (Respondent's Exhibit 7; pp 12-29).

In regard to the accident of December 31, 2008, Dr. Petkovich opined that Petitioner sustained a spinal contusion, primarily to the lumbar spine. He opined that Petitioner was at MMI and not in need of any further medical treatment for that injury (Respondent's Exhibit 7; pp 29-30).

Petitioner was seen by Dr. Joseph Bilyeu on July 16, 2010, for right leg and low back symptoms. He ordered physical therapy which Petitioner received from August 5, through August 24, 2010. In the physical therapy record of August 5, 2010, Petitioner stated that she injured herself at work in December, 2008, when she slipped and fell. That record noted that Petitioner did not remember falling but was found lying flat on her back (Petitioner's Exhibit 22).

Petitioner was seen by Dr. Joseph Williams, an orthopedic surgeon, on May 10, 2011, for her low back pain. At that time, Petitioner completed an intake sheet which stated that she remembered coming out of the bathroom and then waking up laying on her back in liquid Tide with the maintenance man over her asking if she was okay. She also indicated on the form that the accident occurred on December 31, 2009 (not December 31, 2008) and that this was the last date that she had worked (Petitioner's Exhibit 13).

Dr. Williams opined that Petitioner had chronic low back pain, mild lumbar degenerative disc disease, moderate L5-S1 left sided foraminal stenosis and right lower extremity pain. He reviewed an MRI that was performed on March 24, 2011, and opined that surgery was not indicated. He recommended conservative treatment including epidural steroid injections and physical therapy. He initially treated Petitioner from May through September, 2011.

On October 28, 2011, Dr. Williams wrote a letter to Petitioner's counsel wherein he commented on the issue of causality stating: "With regard to the question of causality, is difficult, if not impossible to say whether or not the symptoms that she is currently complaining of are the result of the fall she sustained on December 31, 2008. Ms. Meyer has degenerative disc disease that easily explains her current symptoms. Whether or not she had an exacerbation of her condition secondary to the fall would be difficult to determine from a medical standpoint. If she did in fact have an exacerbation, one would think it would be self-limited." (Petitioner's Exhibit 15).

At trial, Petitioner testified that she was involved in a motor vehicle accident on November 19, 2011, when she was rear-ended by another vehicle. She testified that she sustained injuries to her right knee and neck as result of this accident; however, she also stated that she sustained no injuries to either her low back or left shoulder as a result of that accident.

Following the accident of November 19, 2011, Petitioner was seen at the ER of St. John's Hospital. According to the ER record, Petitioner complained of pain in the right knee, neck, left shoulder and head (Respondent's Exhibit 11).

Petitioner was subsequently seen by Dr. Bilyeu on November 23, 2011. At that time, Petitioner complained of back, shoulder and right knee pain. Dr. Bilyeu ordered an MRI of the right knee (Respondent's Exhibit 14).

On December 15, 2011, Petitioner was evaluated by Dr. Greatting in regard to her left shoulder. According to Dr. Greatting's record of that date, Petitioner informed him that she was not having any problem with her left shoulder except for some occasional discomfort until she sustained the accident of November 19, 2011. Dr. Greatting's impression was "Left shoulder injury due to motor vehicle accident." He ordered a CT arthrogram of the left shoulder (Respondent's Exhibit 13).

On February 21, 2012, Petitioner was again seen by Dr. Williams for both her low back and left shoulder symptoms. Dr. Williams recommended that Petitioner have an MRI of her left shoulder (Petitioner's Exhibit 15).

Dr. Williams subsequently saw Petitioner on March 12, 2012, primarily because of Petitioner's left shoulder pain. His record of that date stated that Petitioner was doing "rather well" until she sustained the motor vehicle accident on November 19, 2011. He described this as being a "new injury" to the left shoulder that occurred as result of the motor vehicle accident of November 19, 2011 (Petitioner's Exhibit 15).

An MRI/arthrogram was performed on Petitioner's left shoulder on March 29, 2012. It revealed that the rotator cuff was intact, that there were post-surgical changes about the shoulder and that there was a slight irregularity or small tear of the labrum (Petitioner's Exhibit 15).

Dr. Williams saw Petitioner on April 20, 2012, primarily for her neck and left shoulder symptoms. He opined that Petitioner had a C3-C4 central disc protrusion and ordered physical therapy. In regard to the left shoulder, he referred Petitioner to Dr. Christopher Maender, an orthopedic surgeon (Petitioner's Exhibit 15).

Dr. Maender evaluated Petitioner on May 9, 2012, and he noted that Petitioner had a 20 year history of left shoulder pain. At that time, Petitioner informed Dr. Maender that prior to the motor vehicle accident, her pain was "tolerable" but that the motor vehicle accident caused her to sustain a rotator cuff tear and shoulder dislocation. Dr. Maender deferred making any treatment recommendations until he reviewed all of the medical records and diagnostic studies (Petitioner's Exhibit 15).

Dr. Maender subsequently saw Petitioner on May 23, 2012. At that time, Dr. Maender opined that further left shoulder surgery was not indicated. He did suggest Petitioner seek another opinion either in St. Louis or Chicago (Petitioner's Exhibit 15).

Petitioner was evaluated by Dr. Leesa Galatz, an orthopedic surgeon, on August 28, 2012. Dr. Galatz examined Petitioner in regard to both her neck and left shoulder symptoms. In regard to the left shoulder, she opined that further left shoulder surgery was not indicated (Petitioner's Exhibit 21).

Dr. Williams was deposed on October 2, 2012, and his deposition testimony was received into evidence at trial. When Dr. Williams was questioned about whether there was a causal relationship between the accident of December 31, 2008, and Petitioner's low back condition he

testified that "It would be nearly impossible for me to state for sure whether or not, with any certainty that fall caused her back pain based on what she said and based on what we see on the MRI. The only thing we could do is show that she had, according to her own history no pain before the fall, and then the pain started after the fall. However, I cannot find any medical evidence on the MRI or the studies that would suggest an acute injury had occurred." Dr. Williams agreed that the fall could have exacerbated the symptoms; however, he opined that this would have been a "temporary exacerbation." In regard to the motor vehicle accident of November 19, 2011, Dr. Williams testified that Petitioner's low back symptoms worsened afterward (Petitioner's Exhibit 16; pp 10-13).

Dr. Maender was deposed on October 19, 2012, and his deposition testimony was received into evidence at trial. In regard to Petitioner's left shoulder condition, Dr. Maender testified that the motor vehicle accident did not have any effect on Petitioner's left shoulder condition. This was based on the history that Petitioner gave to him wherein she informed him that her left shoulder pain was significant both before and after the accident (Petitioner's Exhibit 18; p 10).

On cross-examination, Dr. Maender acknowledged that when Dr. Williams had evaluated Petitioner's left shoulder on March 12, 2012, Petitioner informed Dr. Williams that her left shoulder was doing well prior to the motor vehicle accident of November 19, 2011 (Petitioner's Exhibit 18; pp 21-22).

Petitioner continued to receive medical treatment for her low back symptoms from several medical providers from February, 2013, through January, 2015. This included Dr. Williams, Dr. Per Freitag, Dr. Ferdinand Salvacion and Dr. Windie McKay (Petitioner's Exhibits 15, 20, 24, 25 and 54).

As previously noted herein, Petitioner began working for Springfield Clinic on March 5, 2009, as a Medical Assistant and, even though Petitioner was working, she continued to draw temporary total disability benefits. At trial, Petitioner testified that her job duties included cleaning/stocking examination rooms, preparing patients for doctor visits, organizing the nursing station, etc.

At trial, Petitioner testified that she was a probationary employee for Springfield Clinic and was let go at the end of her probationary period. Petitioner's employment records were received into evidence at trial and they revealed that Petitioner's employment was terminated on June 5, 2009. The records noted that Petitioner had been disciplined for poor job performance; however, the specific reason given for her termination was that she attended a physician's appointment during her scheduled work time and did not seek prior approval or clock out for the appointment. This was considered as theft of time which resulted in her termination (Respondent's Exhibit 6).

When questioned about her termination, Petitioner acknowledged her signature on the document that informed her of her termination. However, Petitioner still stated that she was not advised that the basis for her termination was theft of time.

Petitioner is a Social Security disability recipient and the Deciding awarding benefits was received into evidence at trial. According to the Decision, Petitioner worked until May 30, 2009, because of a second injury. At the time of her Social Security hearing, Petitioner also testified

that she was in a car accident in November, 2011, and she sustained injuries to the left shoulder, back and knee (Respondent's Exhibit 19).

Conclusions of Law

In regard to disputed issue (C) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes that Petitioner sustained an accidental injury arising out of and in the course of her employment for Respondent on September 9, 2008, to her left shoulder.

In support of this conclusion the Arbitrator notes the following:

Petitioner testified that she injured her left shoulder when it struck a door knob as she was in the process of getting up after cleaning a floor.

While the ER records stated that Petitioner struck a "drawer" and not a door knob, the record was otherwise consistent with how this accident occurred.

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 not causally related to the accident of September 9, 2008.

In support of this conclusion the Arbitrator notes the following:

Prior to September 9, 2008, Petitioner sustained a significant injury to her left shoulder which required three surgeries. While Petitioner claimed that she had full use of her left shoulder prior to September 9, 2008, the ER record of that date indicated that Petitioner had a history of dislocated shoulders in the past.

When Petitioner was seen at the ER on September 23, 2008, she stated that her left shoulder seemed to dislocate while sitting at a desk and the record indicated that Petitioner had been there in the past for dislocations and spontaneous reductions of her left shoulder.

Petitioner also informed her physical therapist that her left shoulder dislocated after putting food in a to-go box and that her left shoulder symptoms were worse after she sustained the fall at IHOP on September 23, 2008. At trial, when questioned as to whether she dislocated her left shoulder at the time she sustained the fall at IHOP, Petitioner could not recall.

Respondent's Section 12 examiner, Dr. Petkovich, opined that Petitioner sustained a left shoulder contusion as a result of the accident of September 9, 2008, but that the other left shoulder findings were not related to the accident because they were chronic changes inconsistent with an acute injury.

In regard to the motor vehicle accident of November 19, 2011, Petitioner testified that she did not sustain any further injury to her left shoulder as result of it. However, that is inconsistent

with statements Petitioner made to various medical providers including the ER personnel, Dr. Greatting and Dr. Williams.

While Dr. Maender opined that the motor vehicle accident of November 19, 2011, did not have any effect on Petitioner's left shoulder condition, the Arbitrator assigns no weight to this opinion because it is based upon an inaccurate history provided to him by Petitioner.

When Petitioner's Social Security disability claim was heard, she testified that she sustained an injury to her left shoulder as a result of the November, 2011, motor vehicle accident.

Petitioner returned to work on March 5, 2009, and continued to draw temporary total disability benefits. At trial, Petitioner testified that she did not believe this was improper. Further, Petitioner's employment was terminated on June 5, 2009, because of theft of time. While Petitioner acknowledged her signature on the termination document, she still testified that she did not know that this was the basis for her being terminated.

Based on the preceding, the Arbitrator finds Petitioner's credibility to be highly suspect.

In regard to disputed issue (K) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes that the medical treatment provided to Petitioner on the day of the accident, September 9, 2008, 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 provided to Petitioner on September 9, 2008, of $1,823.23 as identified in Petitioner's Exhibits 30, 42 and 51, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule. All other medical bills are denied.

In regard to disputed issues (K) and (L) the Arbitrator makes the following conclusion of law:

Based on the Arbitrator's conclusion of law in disputed issue (F) the Arbitrator concludes that Petitioner is not entitled to temporary total disability benefits or permanent partial disability benefits.

William R. Gallagher, Arbitrator

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Margaret Meyer,

Petitioner,

vs.

NO: 09 WC 7081

17IWCC0053

Drury Inn,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, temporary 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 October 21, 2015, is hereby affirmed and adopted.

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

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

17IWCC0053

The party commencing 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 31 2017
TJT:yl
o 1/24/17
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MEYER, MARGARET
Employee/Petitioner

Case# **09WC007081**

08WC042329

DRURY INN
Employer/Respondent

17IWCC0053

On 10/21/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.11% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1157 DELANO LAW OFFICES LLC
PATRICK JAMES SMITH
1 S E OLD STATE CAPITAL PLZ
SPRINGFIELD, IL 62701

2396 KNAPP, OHL & GREEN
L DAVID GREEN
6100 CENTER GROVE RD
EDWARDSVILLE, IL 62025

17IWCC0053

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

Margaret Meyer
Employee/Petitioner

v.

Drury Inn
Employer/Respondent

Case # 09 WC 07081

Consolidated cases: 08 WC 42329

An *Application for Adjustment 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 Springfield, on August 21, 2015. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

17IWCC0053

FINDINGS

On December 31, 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 $17,131.40; the average weekly wage was $329.45.

On the date of accident, Petitioner was 34 years of age, married with 4 dependent child(ren).

Petitioner has received all reasonable and necessary medical services.

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

Respondent shall be given a credit of $2,080.00 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $2,080.00.

Respondent is entitled to a credit of $417.60 under Section 8(j) of the Act.

ORDER

Based upon the Arbitrator's conclusions of law attached hereto, claim for compensation is denied.

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

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

William R. Gallagher

William R. Gallagher, Arbitrator

October 16, 2015

Date

OCT 21 2015

Petitioner filed two Applications for Adjustment of Claim which alleged she sustained accidental injuries arising out of and in the course of her employment for Respondent. In case number 08 WC 42329, the Application alleged Petitioner sustained an injury to her left shoulder on September 9, 2008. According to the Application, Petitioner was on the floor cleaning and, when she came up she hit a door knob which caused her to be thrown back down to the floor. In case number 09 WC 07081, the Application alleged Petitioner sustained an injury to her "Left shoulder, cervical, lumbar back and head" on December 31, 2008. According to the Application, Petitioner was walking out of the employees' restroom, slipped and fell hitting her head, back and shoulders (Petitioner's Exhibit 1). Respondent disputed liability in both cases on the basis of accident and causal relationship (Arbitrator's Exhibits 1 and 2). The two cases were previously consolidated for trial.

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Petitioner testified that she injured her left shoulder on September 9, 2008, [in the transcript the question was asked using the incorrect date of September 8, 2008] when her left shoulder struck a door knob as she was getting up after cleaning a floor. Following the accident, Petitioner was seen in the ER of St. John's Hospital. According to the ER records, Petitioner's left shoulder struck a "drawer" and was dislocated. The record also noted that Petitioner had a history of dislocated shoulders in the past and had undergone several surgeries. X-rays were obtained which revealed no evidence of a dislocation. The diagnostic impression was stated as "Dislocated left shoulder with spontaneous reduction." (Petitioner's Exhibit 6).

On September 15, 2008, Petitioner was seen by Dr. Mark Greatting, an orthopedic surgeon, who previously treated Petitioner for left shoulder dislocations. Dr. Greatting's record of that date noted that he performed left shoulder surgery on Petitioner in 1993 and Petitioner subsequently had two more left shoulder surgeries performed in 1996 by Dr. Post in Chicago. Petitioner informed Dr. Greatting that it had been many years since her shoulder had become dislocated. On examination, Dr. Greatting noted that the shoulder was stable and that it was unknown for sure if and when the shoulder actually dislocated. He authorized Petitioner to be off work and ordered physical therapy (Petitioner's Exhibit 6).

On September 23, 2008, Petitioner went to the ER of St. John's Hospital because of left shoulder pain. The ER record stated that Petitioner was sitting at a desk and her left shoulder "seemed to

dislocate." The record also noted that Petitioner had undergone surgery and had been there in the past when the shoulder was dislocated and spontaneously reduced. Again, the diagnostic impression was "Dislocated left shoulder with spontaneous reduction." (Petitioner's Exhibit 6).

Petitioner began physical therapy on October 1, 2008. At that time, Petitioner informed the therapist of the work-related injury of September 9, 2008, as well as the three prior left shoulder surgeries. In that regard, Petitioner advised that the three surgeries were performed because of her having dislocations of her left shoulder (Petitioner's Exhibit 4).

In the physical therapy record of October 16, 2008, it stated that Petitioner was at a restaurant the night before and when she attempted to empty her plate into a to-go box, the left shoulder went out of its socket and back in. The record also stated that Petitioner was going to see her family doctor about her neck and back because she had sustained a fall at IHOP on a wet floor and injured herself (Petitioner's Exhibit 4).

In the physical therapy record of October 23, 2008, the record stated that Petitioner's left shoulder symptoms had been getting worse since "falling at IHOP on 9/23/08." (Petitioner's Exhibit 4). Petitioner was subsequently evaluated by Dr. Jay Riseman, her family physician, on October 27, 2008, for left shoulder and low back pain. This record noted that Petitioner fell at IHOP on October 23, 2008 (Respondent's Exhibit 12).

At trial, when Petitioner was questioned about the fall she sustained at IHOP, she was uncertain as to exactly when it occurred but that it was sometime after September 9, 2008, but before December 31, 2008. Petitioner testified she was going into the bathroom and slipped and fell on her butt. When questioned if she dislocated her left shoulder as a result of this fall, Petitioner stated that she could not recall.

Petitioner had a CT/arthrogram of the left shoulder performed on November 3, 2008. Dr. Greatting saw Petitioner on November 10, 2008, and reviewed the diagnostic study. He opined that it revealed a partial thickness rotator cuff tear and that one of the suture anchors from her previous surgical procedures was out of the bone in the area of the greater tuberosity. He recommended arthroscopic surgery with possible rotator cuff repair and removal of the suture anchor or possible anterior labral repair/stabilization. Dr. Greatting released Petitioner to return to work with restrictions effective December 23, 2008 (Petitioner's Exhibit 4).

In regard to the accident of December 31, 2008, Petitioner testified that she was working light duty and was walking out of an employee bathroom which was adjacent to the laundry room. Petitioner testified that she sustained a slip and fall at that time.

Following the accident of December 31, 2008, Petitioner was taken to the ER of Memorial Medical Center. According to the ER record, Petitioner stated that she was unsure whether she passed out and may have "slipped on detergent." Petitioner was diagnosed with neck and back pain and instructed to see her family physician (Petitioner's Exhibit 2).

At trial, Petitioner said nothing about slipping and falling because of detergent or any other foreign material being on the floor. In regard to the accident of December 31, 2008, three

witnesses testified on behalf of the Respondent. Two of the witnesses testified live at trial and the other was deposed and said deposition was received into evidence at trial.

Flora Coffey was deposed on March 14, 2013, and her deposition testimony was received into evidence at trial. Coffey is retired but was a housekeeper for Respondent during the time Petitioner was employed there. On December 31, 2008, Coffey was folding laundry when Petitioner went to the bathroom. She found Petitioner on the bathroom floor lying on her back. Coffey testified that there was nothing on the floor where Petitioner fell including Tide or any other detergent. She stated that Petitioner complained of left shoulder pain at that time (Respondent's Exhibit 8; pp 9-17).

Ellie Lansing testified at trial. At the time of the accident of December 31, 2008, Lansing was the Assistant Manager. Lansing no longer works for Respondent because she returned to school to become an RN. Lansing testified that she received a telephone call about the accident and went to the location shortly afterward. She stated that she did not see any foreign material including Tide or detergent on the floor where Petitioner fell.

Bobbie Haley testified at trial. Haley has worked for Respondent for 25 years and is the Maintenance Engineer. He also received a call that there had been an accident in the laundry room on December 31, 2008. When he arrived at the scene of the accident, Haley observed Petitioner lying on the floor and stated that there was nothing on the floor where Petitioner fell, nor did he observe anything on Petitioner's clothing or shoes which could have caused her to fall. He also testified that it was not necessary for him to clean the floor afterwards.

Petitioner was seen by Dr. Greatting on January 13, 2009. According to his record of that date, on December 31, Petitioner went to the bathroom, washed her hands and was unaware that Tide had been spilled on the floor. Petitioner slipped on the Tide and remembered waking up on the floor and people over her asking if she was okay. Dr. Greatting's record of that date also noted that "She does not remember actually falling at work which is concerning to me." Dr. Greatting opined Petitioner sustained a bruise of the left shoulder and elbow. He authorized Petitioner to be off work and ordered physical therapy (Petitioner's Exhibit 4).

On January 16, 2009, Petitioner was evaluated by Dr. Cecile Becker, for recurrent falls/blackouts. According to Dr. Becker's record of that date, Petitioner informed her that she fell on December 31, 2008. Petitioner stated that "...she was coming out of the bathroom and the next thing she remembers she was laying on the floor looking upwards." Dr. Becker suspected that Petitioner may have had a seizure so she ordered an EEG. This was performed on January 21, 2009, and was normal (Respondent's Exhibit 13).

Petitioner received physical therapy and, when seen by Dr. Greatting on January 28, 2009, he released Petitioner to return to work without restrictions effective February 9, 2009. When Dr. Greatting saw Petitioner on March 3, 2009, he noted that Petitioner was scheduled for arthroscopic surgery on March 20, 2009 (Petitioner's Exhibit 4).

Petitioner began working for Springfield Clinic on March 5, 2009, as a Medical Assistant. At that time, Petitioner was still receiving temporary total disability benefits. At trial, Petitioner

testified that she did not believe that her continued receipt of temporary total disability benefits was improper.

Dr. Greatting performed arthroscopic surgery on Petitioner's left shoulder on March 20, 2009. The procedure consisted of removal of an intra-articular loose body, subacromial decompression and mini rotator cuff repair (Petitioner's Exhibit 4).

Subsequent to the surgery, Petitioner returned to work for Springfield Clinic on March 26, 2009, and worked 61.75 hours between that date and April 8, 2009 (Respondent's Exhibit 6). Petitioner was continuing to draw temporary total disability benefits during that period of time.

Petitioner was evaluated Midwest Occupational Health Associates (MOHA) on April 30, 2009, for an injury she sustained at Springfield Clinic on April 28, 2009. Petitioner stated that she slipped on some urine on the bathroom floor and fell striking her left elbow on a toilet paper holder and landed on her buttock. Petitioner was diagnosed with a left elbow contusion and lumbar spine contusion. Petitioner was authorized to continue to work full duty (Respondent's Exhibit 13).

On August 12, 2009, Petitioner was evaluated by Dr. William Payne, an orthopedic surgeon, for neck and low back pain. He diagnosed lumbago and cervicalgia and ordered physical therapy. Petitioner received physical therapy for her low back and neck from September 8 through September 29, 2009 (Petitioner's Exhibits 8 and 10).

On September 4, 2009, Petitioner was evaluated by Dr. Kotswara Narla, a neurologist, for her low back and neck pain. In regard to the accident of December 31, 2008, Petitioner informed Dr. Narla she fell at work and remembered waking up on the floor and that they thought she fell on a wet floor. Petitioner also advised Dr. Narla that she had not worked since the fall. Dr. Narla opined that Petitioner had cervical pain with bilateral shoulder radiation and lumbar back pain with bilateral leg radiation. He recommended further diagnostic studies (Petitioner's Exhibit 11).

Dr. Greatting saw Petitioner on September 17, 2009, and he imposed permanent work/activity restrictions in regard to Petitioner's left shoulder. Specifically, Dr. Greatting opined that Petitioner was not to lift more than 10 pounds with her left arm, not to lift more than 10 pounds at waist level, not to lift more than five pounds above the waist to the shoulder level and not to lift more than two pounds above shoulder level (Petitioner's Exhibit 4).

At the direction of Respondent, Petitioner was examined by Dr. Frank Petkovich, an orthopedic surgeon, on March 24, 2010. Dr. Petkovich was deposed on September 30, 2010, and his deposition testimony was received into evidence at trial. Dr. Petkovich testified that he examined Petitioner in regard to both accidents and he reviewed medical records and diagnostic studies that were provided to him. In regard to the accident of September 9, 2008, Dr. Petkovich opined that Petitioner sustained a left shoulder contusion as a result of that accident. Dr. Petkovich further opined that the left shoulder surgery of March 20, 2009, was not related to the September 9, 2008, work injury because all of the operative findings were for chronic changes inconsistent with an acute injury. Further, Dr. Petkovich opined that Petitioner could perform the same work that she was performing prior to September 9, 2008, but that she should have had some

restrictions at that time because she had previously undergone three surgical procedures (Respondent's Exhibit 7; pp 12-29).

In regard to the accident of December 31, 2008, Dr. Petkovich opined that Petitioner sustained a spinal contusion, primarily to the lumbar spine. He opined that Petitioner was at MMI and not in need of any further medical treatment for that injury (Respondent's Exhibit 7; pp 29-30).

Petitioner was seen by Dr. Joseph Bilyeu on July 16, 2010, for right leg and low back symptoms. He ordered physical therapy which Petitioner received from August 5, through August 24, 2010. In the physical therapy record of August 5, 2010, Petitioner stated that she injured herself at work in December, 2008, when she slipped and fell. That record noted that Petitioner did not remember falling but was found lying flat on her back (Petitioner's Exhibit 22).

Petitioner was seen by Dr. Joseph Williams, an orthopedic surgeon, on May 10, 2011, for her low back pain. At that time, Petitioner completed an intake sheet which stated that she remembered coming out of the bathroom and then waking up laying on her back in liquid Tide with the maintenance man over her asking if she was okay. She also indicated on the form that the accident occurred on December 31, 2009 (not December 31, 2008) and that this was the last date that she had worked (Petitioner's Exhibit 13).

Dr. Williams opined that Petitioner had chronic low back pain, mild lumbar degenerative disc disease, moderate L5-S1 left sided foraminal stenosis and right lower extremity pain. He reviewed an MRI that was performed on March 24, 2011, and opined that surgery was not indicated. He recommended conservative treatment including epidural steroid injections and physical therapy. He initially treated Petitioner from May through September, 2011.

On October 28, 2011, Dr. Williams wrote a letter to Petitioner's counsel wherein he commented on the issue of causality stating: "With regard to the question of causality, is difficult, if not impossible to say whether or not the symptoms that she is currently complaining of are the result of the fall she sustained on December 31, 2008. Ms. Meyer has degenerative disc disease that easily explains her current symptoms. Whether or not she had an exacerbation of her condition secondary to the fall would be difficult to determine from a medical standpoint. If she did in fact have an exacerbation, one would think it would be self-limited." (Petitioner's Exhibit 15).

At trial, Petitioner testified that she was involved in a motor vehicle accident on November 19, 2011, when she was rear-ended by another vehicle. She testified that she sustained injuries to her right knee and neck as result of this accident; however, she also stated that she sustained no injuries to either her low back or left shoulder as a result of that accident.

Following the accident of November 19, 2011, Petitioner was seen at the ER of St. John's Hospital. According to the ER record, Petitioner complained of pain in the right knee, neck, left shoulder and head (Respondent's Exhibit 11).

Petitioner was subsequently seen by Dr. Bilyeu on November 23, 2011. At that time, Petitioner complained of back, shoulder and right knee pain. Dr. Bilyeu ordered an MRI of the right knee (Respondent's Exhibit 14).

On December 15, 2011, Petitioner was evaluated by Dr. Greatting in regard to her left shoulder. According to Dr. Greatting's record of that date, Petitioner informed him that she was not having any problem with her left shoulder except for some occasional discomfort until she sustained the accident of November 19, 2011. Dr. Greatting's impression was "Left shoulder injury due to motor vehicle accident." He ordered a CT arthrogram of the left shoulder (Respondent's Exhibit 13).

On February 21, 2012, Petitioner was again seen by Dr. Williams for both her low back and left shoulder symptoms. Dr. Williams recommended that Petitioner have an MRI of her left shoulder (Petitioner's Exhibit 15).

Dr. Williams subsequently saw Petitioner on March 12, 2012, primarily because of Petitioner's left shoulder pain. His record of that date stated that Petitioner was doing "rather well" until she sustained the motor vehicle accident on November 19, 2011. He described this as being a "new injury" to the left shoulder that occurred as result of the motor vehicle accident of November 19, 2011 (Petitioner's Exhibit 15).

An MRI/arthrogram was performed on Petitioner's left shoulder on March 29, 2012. It revealed that the rotator cuff was intact, that there were post-surgical changes about the shoulder and that there was a slight irregularity or small tear of the labrum (Petitioner's Exhibit 15).

Dr. Williams saw Petitioner on April 20, 2012, primarily for her neck and left shoulder symptoms. He opined that Petitioner had a C3-C4 central disc protrusion and ordered physical therapy. In regard to the left shoulder, he referred Petitioner to Dr. Christopher Maender, an orthopedic surgeon (Petitioner's Exhibit 15).

Dr. Maender evaluated Petitioner on May 9, 2012, and he noted that Petitioner had a 20 year history of left shoulder pain. At that time, Petitioner informed Dr. Maender that prior to the motor vehicle accident, her pain was "tolerable" but that the motor vehicle accident caused her to sustain a rotator cuff tear and shoulder dislocation. Dr. Maender deferred making any treatment recommendations until he reviewed all of the medical records and diagnostic studies (Petitioner's Exhibit 15).

Dr. Maender subsequently saw Petitioner on May 23, 2012. At that time, Dr. Maender opined that further left shoulder surgery was not indicated. He did suggest Petitioner seek another opinion either in St. Louis or Chicago (Petitioner's Exhibit 15).

Petitioner was evaluated by Dr. Leesa Galatz, an orthopedic surgeon, on August 28, 2012. Dr. Galatz examined Petitioner in regard to both her neck and left shoulder symptoms. In regard to the left shoulder, she opined that further left shoulder surgery was not indicated (Petitioner's Exhibit 21).

Dr. Williams was deposed on October 2, 2012, and his deposition testimony was received into evidence at trial. When Dr. Williams was questioned about whether there was a causal relationship between the accident of December 31, 2008, and Petitioner's low back condition he

testified that "It would be nearly impossible for me to state for sure whether or not, with any certainty that fall caused her back pain based on what she said and based on what we see on the MRI. The only thing we could do is show that she had, according to her own history no pain before the fall, and then the pain started after the fall. However, I cannot find any medical evidence on the MRI or the studies that would suggest an acute injury had occurred." Dr. Williams agreed that the fall could have exacerbated the symptoms; however, he opined that this would have been a "temporary exacerbation." In regard to the motor vehicle accident of November 19, 2011, Dr. Williams testified that Petitioner's low back symptoms worsened afterward (Petitioner's Exhibit 16; pp 10-13).

Dr. Maender was deposed on October 19, 2012, and his deposition testimony was received into evidence at trial. In regard to Petitioner's left shoulder condition, Dr. Maender testified that the motor vehicle accident did not have any effect on Petitioner's left shoulder condition. This was based on the history that Petitioner gave to him wherein she informed him that her left shoulder pain was significant both before and after the accident (Petitioner's Exhibit 18; p 10).

On cross-examination, Dr. Maender acknowledged that when Dr. Williams had evaluated Petitioner's left shoulder on March 12, 2012, Petitioner informed Dr. Williams that her left shoulder was doing well prior to the motor vehicle accident of November 19, 2011 (Petitioner's Exhibit 18; pp 21-22).

Petitioner continued to receive medical treatment for her low back symptoms from several medical providers from February, 2013, through January, 2015. This included Dr. Williams, Dr. Per Freitag, Dr. Ferdinand Salvacion and Dr. Windie McKay (Petitioner's Exhibits 15, 20, 24, 25 and 54).

As previously noted herein, Petitioner began working for Springfield Clinic on March 5, 2009, as a Medical Assistant and, even though Petitioner was working, she continued to draw temporary total disability benefits. At trial, Petitioner testified that her job duties included cleaning/stocking examination rooms, preparing patients for doctor visits, organizing the nursing station, etc.

At trial, Petitioner testified that she was a probationary employee for Springfield Clinic and was let go at the end of her probationary period. Petitioner's employment records were received into evidence at trial and they revealed that Petitioner's employment was terminated on June 5, 2009. The records noted that Petitioner had been disciplined for poor job performance; however, the specific reason given for her termination was that she attended a physician's appointment during her scheduled work time and did not seek prior approval or clock out for the appointment. This was considered as theft of time which resulted in her termination (Respondent's Exhibit 6).

When questioned about her termination, Petitioner acknowledged her signature on the document that informed her of her termination. However, Petitioner still stated that she was not advised that the basis for her termination was theft of time.

Petitioner is a Social Security disability recipient and the Deciding awarding benefits was received into evidence at trial. According to the Decision, Petitioner worked until May 30, 2009, because of a second injury. At the time of her Social Security hearing, Petitioner also testified

that she was in a car accident in November, 2011, and she sustained injuries to the left shoulder, back and knee (Respondent's Exhibit 19).

Conclusions of Law

In regard to disputed issue (C) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes that Petitioner did not sustain an accidental injury arising out of and in the course of her employment for Respondent on December 31, 2008.

In support of this conclusion the Arbitrator notes the following:

At trial, Petitioner initially testified that she sustained a slip and fall while walking out of the bathroom which was adjacent to the laundry room. She said nothing about slipping and falling on detergent on the floor although that statement was made in some of the medical records.

Three witnesses testified on behalf of the Respondent, Flora Coffey, Ellie Lansing and Bobbie Haley. All three of these witnesses testified that there was no detergent or any foreign material on the floor where Petitioner sustained the fall. Two of the three witnesses, Coffey and Lansing, are no longer employed by Respondent. The Arbitrator finds their testimony to be credible.

When Petitioner was seen by Dr. Greatting, Dr. Becker and Dr. Bilyeu you, she said nothing about slipping and falling because of detergent or some foreign matter being on the floor. She informed them that she was coming out of the bathroom and was subsequently lying on the floor without any specific recollection as to how the fall occurred.

When Petitioner was subsequently seen by Dr. Williams, she gave a slightly different history in that she remembered coming out the bathroom and then waking up laying on her back in liquid Tide; however, even then she did not specifically state that the liquid detergent caused her to fall.

Petitioner returned to work on March 5, 2009, and continued to draw temporary total disability benefits. At trial, Petitioner testified that she did not believe that this was improper. Further, Petitioner's employment was terminated on June 5, 2009, because of theft of time. While Petitioner acknowledged her signature on the termination document, she still testified that she did not know that this was the basis for her termination.

Based on the preceding, the Arbitrator finds Petitioner's credibility to be highly suspect.

In regard to disputed issues (F), (J), (K) and (L) the Arbitrator makes no conclusions of law as these issues are rendered moot because of the Arbitrator's conclusion of law in disputed issue (C).

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Phillip Mumford,
Petitioner,

vs.

NO: 11 WC 14916

17IWCC0054

Jackson Park Hospital,
Respondent.

DECISION AND OPINION ON REVIEW

This case was originally before Arbitrator Mason pursuant to §19(b) of the Illinois Workers' Compensation Act. The Arbitrator found Petitioner sustained an accidental injury arising out of and in the course of his employment on March 24, 2011. As a result, Petitioner was temporarily totally disabled from March 25, 2011 through April 2, 2011 and April 11, 2011 through October 9, 2012 for 79-4/7 weeks under §19(b) of the Act, is entitled to the medical bills contained in Petitioner's PX11 with the exception of Dr. Forman's multiple $60.00 charges for narration reports and the multiple $275.00 charges for the non-emergency transportation.

Respondent filed a Petition for Review. On May 2, 2013, the Commission affirmed the Arbitrator's decision and remanded the case to the arbitrator for further proceeding, including but not limited to a finding of permanency. The case was assigned to Arbitrator Gale.

Currently the claim is before the Commission on Petitioner's appeal of Arbitrator Gale's decision in which he found that Petitioner was temporarily totally disabled from March 25, 2011 through April 2, 2011 and April 11, 2011 through September 16, 2013 for 128-3/7 weeks under §19(b) of the Act, is entitled to $2,265.96 in medical expenses under §8(a) of the Act. The Arbitrator further denied the cost of Petitioner's mail order prescriptions finding they are not covered under the medical fee schedule as set forth in the Act. The Arbitrator found that Petitioner's treaters lack unanimity as to what type of medical care is required for the Petitioner. Petitioner does not present with surgery indications at any particular level and as such the

17IWCC0054

Arbitrator will not require Respondent to provide surgery care at this time. The Arbitrator found due to Petitioner's pain complaints Petitioner is entitled to palliative care to relieve his condition of ill-being and the Arbitrator will not terminate the right to ongoing care. The Arbitrator suggested that another doctor look at Petitioner's condition and, if need be, that Petitioner undergo more testing to determine if surgery is necessary. Lastly, Respondent is entitled to a credit of $31,428.48 in temporary total disability benefits and $3,960.00 for a permanent partial disability advance.

The issues on Review are whether a causal relationship exists between the March 24, 2011 work accident and Petitioner's current condition of ill-being and/or need for medical services, and if so, the extent of Petitioner's temporary total disability and the amount of reasonable and necessary medical expenses.

The Commission, after reviewing the entire record, modifies the Arbitrator's decision and finds Petitioner failed to prove he is entitled to surgery at this time. In addition to the medical bills which have already been awarded, Petitioner is entitled to the prescription bills that were submitted into the record and Petitioner is further entitled to the medical bills contained in Petitioner's PX4A and PX5A subject to the medical fee schedule. The Commission further finds Petitioner was temporarily totally disabled from March 25, 2011 through April 2, 2011 and April 11, 2011 through January 14, 2016, the date of the last Arbitration hearing. Lastly, the Commission finds that this case should be remanded to the Arbitrator for further proceedings pursuant to Thomas v. Industrial Commission, 78 Ill. 2d 327 (1980), for the reasons set forth below.

FINDNG OF FACTS AND CONCLUSIONS OF LAW

The Commission finds:

1. Petitioner, a 41 year old patient transporter, sustained an accident on March 24, 2011. The following testimony from the Petitioner relates to what occurred after the last October 2012 Arbitration hearing.

2. Petitioner testified that his pain is worse since 2012. He even experiences the pain when he is sitting still. If he sits too long, his legs go to sleep and he has pins and needles in both feet. He cannot go up or down stairs. The worst pain is in his back. Since the last time he testified in front of the Arbitrator he has been totally dependent on medications and his pain is consistent and ongoing. He agreed that the pain varies and sometimes it gets bad while other times it is not as bad. The pain is generally on both sides of his lower back and it radiates down into both legs. It switches as to which leg the pain radiates into. Petitioner said he wants to get surgery. He has been disabled by the doctors since the accident and he does not drive. He testified that he cannot bend or twist without the pain radiating. He carries bags of food but he makes them as light as possible. It is harder for him to deal with the pain in the winter than in the summer. Petitioner testified that he

attempted physical therapy after the last arbitration hearing. Outside of physical therapy he has not been able to perform any physical activities. He has not attempted to procure any form of employment.

The pertinent medical evidence is as follows:

3. The May 19, 2011 lumbar MRI ordered by Dr. Foreman showed that at the L5-S1 level there is a 2-3 mm subligamentous posterior disc protrusion/herniation slightly elevating the posterior longitudinal ligament and indenting the ventral surface of the thecal sac without significant spinal stenosis, nor significant neuroforaminal narrowing; The rest of the lumbar spine appeared unremarkable.

4. On June 6, 2011 Petitioner was seen at Chicago Pain and Orthopedic Institute by Dr. Jain. The Petitioner reported that on March 24, 2011 he was lifting a patient in a hospital bed when he felt a sudden onset of back pain, which is somewhat greater on the left and has resulted in radiation into left lower extremity. Petitioner reports the pain is unchanged and it is still severe. He reports that he experiences a constant aching, stabbing type sensation with pressure and the pain increases with walking, bending backwards and forwards. It improved initially when he lies down but now he has significant pain and difficulty finding a comfortable position while lying down at night. Typically changing positions will relieve the pain and medications help somewhat. He describes the pain as a constant, aching, shooting, throbbing type pain. The pain radiates both into his groin and testicles as well as his left lower extremity. He has some weakness in the left leg at times. He has difficulty climbing stairs or doing any activities for a prolonged period of time. He is very sedentary even in terms of activities of daily living. He has not been able to return to work since the injury. The patient's MRI showed fairly substantial disc herniations/protrusion at L5-S1 but it is not causing significant neural foraminal narrowing. The June 17, 2011 EMG/NCV reported right L4 and bilateral L5 lumbar radiculopathy. Dr. Jain recommended that Petitioner receive a bilateral L5-S1 transforaminal epidural steroid injection with a selective nerve root block. In the meantime, Petitioner should continue with physical therapy. He will be given medication, will continue using a TENS unit and will be off of work.

5. On June 28, 2011, Petitioner was given a bilateral L5-S1 and S1 transforaminal epidural steroid injection with a selective nerve root block. On July 6, 2011, Petitioner followed up with Dr. Jain who noted that Petitioner reported a 10% improvement after the injection. Dr. Jain advised Petitioner to undergo a repeat injection. On August 9, 2011, a second injection took place. Petitioner was given a facet joint injection at L3-4, L4-5 and L5-S1 along with a selective nerve root block. After the second injection, Petitioner reported to Dr. Jain that he had a 20% improvement and Dr. Jain ordered L3-S1 median branch blocks.

6. On September 20, 2011, bilateral median branch blocks were given at L3, L4, L5-S1 and at the dorsal root of L5 medial branch nerve along with blocks being given to the facet joints at L3-4, L4-5, L5-S1. On October 10, 2011, Petitioner reported to Dr. Jain that he experienced increased back pain after the blocks along with numbness in his left leg. More specifically, Petitioner reported he experienced a flare up for two days after injection and on third day the pain returned to his baseline. Dr. Jain prescribed a discogram for the Petitioner.

7. On September 16, 2013, Petitioner was evaluated by Dr. Kornblatt. The doctor indicated that he reviewed the May 19, 2011 lumbar MRI and found it was a normal MRI scan with no evidence of disc desiccation, herniated disc, spinal stenosis, nerve root impingement, or bony pathologic changes. The doctor indicated that he reviewed the EMG findings and found they were within the normal limits. Overall, he found Petitioner's lumbar spine appeared to be objectively within normal limits. Furthermore, Petitioner presented without any abnormal objective findings on his examination and his x-rays were normal. While Petitioner presented subjective complaints of chronic mechanical low back pain, Dr. Kornblatt opined that his examination showed no objective findings which would justify his ongoing subjective complaints. Dr. Kornblatt opined that Petitioner experienced a work related lumbosacral strain. He further opined that Petitioner should have reached maximum medical improvement within 5-6 weeks after the work incident. Lastly, he found that Petitioner was not in need of any formal medical care for his low back and Petitioner had reached maximum medical improvement by late May 2011.

8. The December 23, 2013 CT scan showed that at L2-3 and L3-4 there were no significant posterior disc bulges, protrusions or herniations. There was no spinal stenosis or significant neuroforaminal narrowing seen. At L4-5 there was a 2-3 mm posterior disc bulge indenting the thecal sac without significant spinal stenosis or significant neuroforaminal narrowing. The radiologist opined that this was probably a Dallas Classification, Type II. He noted that at the L5-S1 level there was also a 2-3 mm posterior disc bulge indenting the thecal sac without any significant spinal stenosis or significant neuroforaminal narrowing. This is also probably a Dallas Classification, Type II.

9. On December 24, 2013, a discogram was ordered by Dr. Vargus and he noted that the diagnostic provocative functional lumbar discography at L2-3, L3-4, L4-5 and L5-S1 showed no pain at L2-L3 and L3-4, mild pain at L4-5 and concordant pain at L5-S1. The L2-L3 level demonstrated minimal degeneration while the L3-L4 level showed mild degeneration. At the L4-5 level, there was bilocular dye pooling above and below the central nuclear cavity with degeneration. On the lateral, view there was bilocular dye pooling above and below the central nuclear cavity with anterior spread limited by the annular wall. There is no extravasation or herniation into the spinal canal. The L5-S1 level demonstrated bilocular dye pooling above and below the central nuclear cavity with clear degeneration. On the lateral view, there was bilocular dye pooling above and below

the central nuclear cavity with extension of the contrast into the ventral and lateral aspect of the annular which Dr. Vargus opined was consistent with a grade IV annular tear. He further opined that there were clear extravasation and herniation into the spinal canal and possibly into the both foraminae.

10. During the January 10, 2014 follow up appointment with Dr. Vargus, the doctor diagnosed intractable chronic low back pain syndrome, chronic intractable lumbar discogenic radiculopathy, L5-S1 herniated discs and lumbar facet pain syndrome. Dr. Vargus found that the discogram clearly revealed discogenic pain which was concordant intraoperatively with his ongoing pain at L5-S1 levels. Similarly the intraoperative morphology of the involved discs along with a post diskogram CT clearly confirmed these findings. He instructed Petitioner to continue to take the medication as prescribed. He discussed a surgical decompression and possible fusion surgery with the Petitioner. Lastly, he refilled Petitioner's prescriptions and told him to remain off of work.

11. On April 2, 2014, Petitioner saw Dr. Dixon at Chicago Neurological Surgery. The doctor noted that Petitioner's May 9, 2011 (sic 5/19/11) MRI demonstrated degenerative disc disease with some broad based disc protrusions and lateral recess/foraminal stenosis at L4-5 with nerve root compression. He noted that Petitioner's December 2013 diskogram demonstrated concordant pain at the recess along with foraminal stenosis at L4-5 with nerve root compression. His August 2011 EMG demonstrated bilateral L4 and L5 radiculopathies at the L4-5 level. He ordered Petitioner to undergo a new lumbar MRI.

12. The April 9, 2014 lumbar MRI showed at L2-3 there was a right lateral annular tear. There was no spinal or neural foraminal stenosis. At L3-4, there was 1.5 mm diffuse disc bulging flattening the thecal sac and hypertrophy of facet joints and ligamentum flavum. There was mild bilateral neural foraminal stenosis. At L4-5, there was 2 mm diffuse disc bulging and hypertrophy of facet joints. There was mild spinal and bilateral neural foraminal stenosis.

13. During the April 16, 2014 follow up visit with Dr. Dixon, the doctor noted that the April 9, 2014 MRI demonstrated a foraminal herniated disc herniation at L2-3 compression the nerve in the foramen as well degenerative disc disease with some broad based disc protrusion and lateral recess/foraminal stenosis at L4-5 with nerve root compression. The L2-L3 discogram demonstrated concordant pain at L4-5 with grade 3-4 degeneration. Dr. Dixon recommended that Petitioner undergo surgery consisting of a right L2-3 microlumbar discectomy and L4-5 laminectomy with L4-5 interbody fusion and pedicle screw instrumentation.

14. On May 9, 2014, Petitioner saw Dr. Vargas. The doctor diagnosed Petitioner with intractable chronic low back pain, chronic intractable lumbar discogenic radiculopathy, a L5-S1 herniated disc and lumbar facet pain syndrome. Dr. Vargas opined that Petitioner has remained status quo from clinical standpoint and he is currently awaiting

authorization for a lumbar spinal decompression surgery and fusion to be performed by Dr. Dixon. Dr. Vargas refilled Petitioner's prescription and stated that Petitioner should remain off work. In a May 28, 2014 visit with Dr. Dixon, the doctor also found Petitioner has remained status quo.

15. On June 26, 2014, Dr. Kornblatt produced an addendum evaluation report. Dr. Kornblatt noted that he had recently performed a record review which including reviewing a prior IME report, medical records from Drs. Vargas and Dixon along with Petitioner's May 19, 2011 MRI and December 24, 2013 discogram. Upon reviewing these records, Dr. Kornball still opined that Petitioner was not a surgical candidate. Dr. Kornblatt said that the December 24, 2013 discogram was consistent with very mild L4-5 and L5-S1 degenerative disc disease. He opined that the degenerative disc disease is unrelated to Petitioner's March 24, 2011 work incident. He noted that in his earlier September 19, 2013 evaluation report he found Petitioner was capable of working with a 30 pound lifting restriction for 3 weeks and during this period his restrictions would lessen and Petitioner should be capable of returning to full, gainful employment.

16. On August 29, 2014, Petitioner was seen by Dr. Patel at the Chicago Pain and Orthopedic Institute. Dr. Patel noted that Petitioner is awaiting decompression and fusion surgery. He noted that Petitioner's discography showed conformed discogenic pain as well as lumbosacral radiculitis symptoms. Dr. Patel opined that Petitioner also appears to have significant myofascial components to his pain. He found that as a result of his extended use of his back brace, Petitioner presented with a significant amount of deconditioning, a loss of range of motion as well as paraspinal and core weakening. He noted that Petitioner is currently using Teracin cream and taking Gabapentin and Tramadol. Petitioner also reported he uses Flexeril on a rare basis. Dr. Patel give Petitioner a prescription to refill his Tramadol and Gabapentin along with a prescription for Teracin patches.

17. On June 26, 2014, Dr. Kornblatt issued an addendum report in which he indicated that he has reviewed the April 9, 2014 lumbar MRI along with the December 23, 2013 CT and he found that his opinion was unchanged from his prior September 16, 2013 evaluation. He found that the additional reports failed to reveal any radiographic surgical lesions of the lumbar spine.

18. On February 11, 2015, Petitioner followed up with Dr. Dixon who found that Petitioner's condition was status quo.

19. On November 16, 2015, Petitioner saw Dr. Pontinen at the Chicago Pain and Orthopedic Institute. Dr. Pontinen noted that Petitioner has had chronic lumbar radicular pain since he was involved in a 2011 work accident and currently he is awaiting surgery. He noted that Petitioner reports his pain is unchanged since his visit in April of 2014. At that time Dr. Dixon suggested surgery consisting of a discectomy at L2-3 and a

laminectomy/fusion at L4-5 and Petitioner is still awaiting approval for surgery. Petitioner reported that prior to this he had multiple injections and underwent physical therapy but these treatments did not help. He reported that he has not worked since his injury and he is currently considering applying for disability. He reports that his back brace has broken and he needs another one. Dr. Pontinen reviewed Petitioner's 2011 EMG, 2013 discogram and 2014 lumbar MRI and diagnosed Petitioner as having lumbago, radicular low back pain and a displaced lumbar inverted disc.

20. On December 28, 2015, Petitioner saw Physician Assistant Nisavic at the Chicago Pain and Orthopedic Institute. It was noted that Petitioner is here today for follow up of his chronic lumbar radicular pain. He is awaiting approval for the surgery recommended by Dr. Dixon. He is doing physical therapy now and he just has a couple of days left. He does not want to renew the physical therapy prescription because physical therapy is just too painful. He reports it is even too uncomfortable to sit and he has to keep moving. He reported his pain is currently a 8 out of 10 on a 10 point scale. Physician Assistant Nisavic refilled Petitioner's medication and advised him to follow up in one month and to continue to stay off of work.

21. Dr. Dixon, a board certified, neurological surgeon, was deposed on April 23, 2015. He testified that he first saw Petitioner on April 2, 2014. He found on examination that Petitioner demonstrated a decrease in strength in the tibialis anterior and the extensor halluces longus on his right side. He reviewed the May 9, 2011(sic 5/19/11) MRI, the December 2013 discogram and the August 2011 EMG. He ordered a new MRI because the last one was almost three years old. He also reviewed the May 9, 2011 films.

Dr. Dixon found that the radiologist's MRI report indicated that at L5-S1 there was a 2-3 mm subligamentous posterior disc protrusion herniated slightly elevating the posterior longitudinal ligament and indenting the ventral surface of the thecal sac without significant spinal stenosis or significant neuroforaminal narrow. Dr. Dixon testified that when he read the film, he found that there was degenerative disc disease with some broad-based disc protrusions and lateral recess and foraminal stenosis at L4-5 along with nerve root compression.

His review of the newer MRI films from April 9, 2014 demonstrated a foraminal herniated disc between the L2 and L3 level with a compression of the nerve root within the foramen as well as degenerative disc disease. It also showed a broad-based disc protrusion and lateral recess and foraminal stenosis at L4-5 with nerve root compression. The radiologist also identified a right lateral annular tear at L2-L3. There was no spinal or neuroforaminal stenosis at L3-4. There was a 1.5 millimeter diffused disc bulging with flattening of the thecal sac and hypertrophy of the facet joints and ligamentum flavum. There was mild bilateral neuroforaminal stenosis. At L4-5 there was a 2 mm disc bulge along with hypertrophy of facet joints. There was also mild spinal and bilateral

neuroforaminal stenosis. At L5-S1 there is a 2mm diffused disc bulge and hypertrophy of facet joints. There is mild bilateral and neuroforaminal stenosis.

Dr. Dixon agreed that the December 24, 2013 discogram report showed concordant pain at L4-5 with a grade 3-4 degenerative herniated of the disc. When he looked at the report, he believed there was mild pain at L4-5 level, which was characterized as discordant. There was a lobular horseshoe pattern of disc morphology as well as degeneration and fissuring. Those findings were differentiated from L5-S1 where there was excruciating pain that was characterized as concordant with morphology being lobular, degenerated, and ruptured. Dr. Dixon said that since he was not the person who performed the test he cannot say definitively what the testor meant by the term "discordant". Dr. Dixon agreed that the April 2014 EMG also demonstrated L4-5 radiculopathy.

Based on these tests, he made a recommendation that Petitioner consider surgery, which would include an evaluation of the L2-3 level via microlumbar discectomy as well as an L4-5 laminectomy and decompression with an interbody fusion and pedicle screw instrumentation at that level. He did not mention doing anything regarding the L5-S1 level based on his evaluation of the patient and specifically his examination which demonstrated a decrease in strength in the tibialis anterior and extensor halluces longus. He said these findings correlate with the L5 nerve root, which is typically compressed by problems at the L4-5 level. He used that in combination with the EMG findings to suggest surgery to the Petitioner. He believed that the surgery would address the preponderance of Petitioner's symptoms in the most straightforward fashion.

Dr. Dixon testified that he did not find any inconsistency between the older and newer MRIs. His interpretation of the 2014 MRI demonstrated similar pathology at the L4-5 level with additional pathology that certainly could have emanated from either the injury or simply the passage of time. His inclination was to use the information he had available and specifically his own interpretation of the MRI, the EMG and his examination to recommend the surgery for the Petitioner that he thought would be most effective for the preponderance of the symptoms he identified. He believes that there are a number of reasons that more than one level did not show up in the MRI. The most common would be that in order for something to have become symptomatic, it does not necessarily have to be demonstrated in MRI findings. Dr. Dixon said we routinely see people who develop radiculopathy or radiculitis related to a traumatic event without an MRI finding of compression at that level. One, possible reason is that it could be interpreted as inflammation or an irritation. A second possible explanation could be that he interpreted the MRI differently than the radiologist did at the time he read it. Dr. Dixon testified that he interpreted a finding of an issue at L4-5 even in 2011. When Dr. Dixon was asked to comment on the other disc protrusions shown in the 2014 MRI, he said that one of the things that is probably most confounding in dealing with spinal pathology is just the idea of degenerative changes. He said that something could have

been initiated at that incident that would not have been readily apparent at that time of the event but once three years has elapsed it might be more easily identifiable on a later MRI.

Dr. Dixon testified that based on the fact that Petitioner did not relate that he was experiencing any pain prior to the incident and he had significant pain after the incident that prohibited him from working, it was his opinion that the March 24, 2011 work related injury is the cause of Petitioner's spinal pathology. He further stated that based on his evaluation of the images and reports that are available and his own neurologic exam of the Petitioner, he has recommended that Petitioner undergo surgery consisting if a discectomy and decompression at L2-3 as well as a laminectomy and decompression with interbody fusion and instrumentation at L4-5.

When Dr. Dixon was asked if Petitioner had symptoms arising from the L2-3 level he stated that his recollection is that Petitioner complained of pain in the right leg that also radiated into the groin and that this pain would be attributable to a disc herniation at L2-3. So the lack of a notation to that effect would be an oversight on his part.

Dr. Dixon said that if Petitioner were to continue under his care while awaiting authorization for the surgery he would likely repeat Petitioner's EMG and assuming that those new results are similar and/or unchanged from his prior EMG he would use the information he has from the April 2014 MRI even though it is a year old now. However, if the EMG showed something different he would have to try to reconcile this information by possibly repeating the MRI or the discogram.

On cross-examination, Dr. Dixon said he first examined Petitioner on April 2, 2014 which was a little over three years after the March 24, 2011 incident. At that time, he diagnosed Petitioner as having a L4-5 degeneration/herniated disc with an L4-5 radiculopathy. In order to form this diagnosis, he reviewed the records of Dr. Vargas as well as some earlier notation from Dr. Jain. If Dr. Vargas said that L5-S1 is the only symptomatic level, he disagrees with him. Dr. Dixon said that the surgery he has recommended does not indicate by name the L5-S1 level because he does not believe that the L5-S1 level is the culprit of Petitioner's symptomatology. He agreed that he cannot opine with a reasonable degree of medical certainty that the other levels that manifested themselves on May 19, 2014 and not earlier at the time of the 2011 MRI are related to the March 24, 2011 work accident. When Dr. Dixon was asked if he would agree that the surgery he is recommending include levels of his lumbar spine that he cannot with a reasonable degree of medical certainty relate to the March 24, 2011 work accident, Dr. Dixon said that the point of the surgery is to attempt to address the pathology that he saw at that time. He said he has used his interpretation of both MRIs, the EMG and his examination to explain why he thinks the level is L4-5 is the correct level to in which to conduct the surgery. He said those tests correlate with his belief that the L4-5 level is the correct level in which to perform surgery. The only test that differs from this is the

discogram and he has chosen to use the preponderance of the evidence to suggest where the treatment should occur.

22. Dr. Kornblatt, a board certified orthopedic surgeon, was deposed on November 9, 2015. He said that 99% of his patients have spinal issues. Dr. Kornblatt said that there is a difference between Dr. Vargas' diagnosis and Dr. Dixon's diagnosis. After reviewing the tests and conducting his own examination, he found that Petitioner had no surgical lesions in his lumbar spine. As such, he disagrees with both Drs. Vargas' and Dixon's opinions that Petitioner is a surgical candidate. He testified that if Dr. Dixon states he's going to do surgery at L4-5 and Dr. Vargas says L5-S1 is the symptomatic level, obvious there is a disagreement between the two doctors as to what treatment is supposed to be given to the Petitioner and it further confirms the fact that the Petitioner is not a surgical candidate.

There is sufficient evidence which demonstrates that Petitioner has failed to prove, via the disparate opinions of the doctors', that he is currently a viable surgery candidate. The Commission notes that given the fact that Petitioner's claim is before the Commission pursuant to Section 19(b) of the Act, which is indicative of the fact that Petitioner's condition has not yet reached a permanent state, and there appears to be some evidence that Petitioner's condition more probably than not may benefit from surgery, the Commission finds that there is still an opportunity for Petitioner to provide further evidence under an additional Section 19(b) filing to supports the fact that he is in need of prospective medical treatment. As such, the Commission finds that this claim in not sufficiently ripe at this time to make a determination regarding prospective medical treatment on behalf of the Petitioner and that the claim should be remanded to the Arbitrator with instructions to accept additional evidence regarding this issue prior to a determination of whether or not Petitioner's condition has reached a permanent state.

In terms of the current medical bills, the Commission finds that the Arbitrator did not award any of the mail order pharmacy bills and he found that they were not covered by the fee schedule. Additionally, the Arbitrator found that the remaining bills were not reasonable under Section 8(a) of the Act.

In terms of the outstanding current medical bills, there are two bills in question. One, is PX4A which is a bill from Prescription Partners that shows an outstanding balance due of $983.97. It indicates that the outstanding balance is for medication dispensed by Dr. Vargas of the Chicago Pain and Orthopedic Institute. The second bill is PX5A a patient statement from RX Development Associates showing the facility as Chicago Pain and Orthopedics, the prescriptions dispensed as Terocin, Tramadol, Hydrocodone, Fexmid, Protonix, Ambient, Mobic, Neurontin, Flexeril and further showing dates of service covering the periods of March 7, 2014 through August 29, 2014 and indicating balance of $13,327.29 is due and owing.

The Commission notes that the medical entries above and particularly Dr. Patel's August 29, 2014 entry which spells out the medication Petitioner is currently taking and the doctor is prescribing along with Dr. Vargus' January 10, 2014 and May 9, 2014 entries provide the foundational basis for finding that these bills are reasonable and necessary prescription bills and are properly covered by the fee schedule. As such, the Commission awards the medical bills contained in Petitioner's PX4A and PX5A so long as they are subject to the medical fee schedule.

The Commission finds that the medical records and/or opinions above show that Petitioner sustained more than a back sprain as diagnosed by Dr. Komblatt and that Petitioner's condition has not yet stabilized. As such, the Commission modifies the Arbitrator's decision and awards temporary total disability through January 14, 2016, the date of the last Arbitration hearing.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $241.91 per week for a period of 249-1/7 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 pay to Petitioner $1,003.04 for the Chicago Pain and Spine Institute bill, $1,262.92 for the Preferred Open MRI bill and all the mail order pharmaceutical bills under §8(a) and §8.2 of the Act.

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

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

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit in the amount of $31,428.48 for payment of temporary total disability benefits and $3,960.00 for a permanent partial disability advance for a total credit of $35,388.48 paid to or on behalf of Petitioner on account of said accidental injury.

17IWCC0054

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $41,600.00. 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 31 2017

Mario Basurto

David L. Gore

Stephen Mathis

MB/jm

O: 12/15/16

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STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Russell McGurty,
Petitioner,

vs.

NO: 15 WC 18870

17IWCC0055

ABF Freight,
Respondent.

DECISION AND OPINION ON REVIEW

Petitioner appeals the decision of Arbitrator Williams finding that Petitioner sustained an accidental injury arising out of and in the course of his employment on May 10, 2015. The Arbitrator further found Petitioner's neck and back conditions are causally related to the May 10, 2015 accident through July 10, 2015 but Petitioner's left hip condition and the proposed surgery are not causally related to the May 10, 2015 work accident. As a result of the accident, Petitioner was temporarily totally disabled from May 11, 2015 through July 10, 2015 for 4-3/7 weeks under Section 19(b) of the Illinois Workers' Compensation Act. Respondent is entitled to a credit of $8,599.28 for payment of temporary total disability benefits and $5,882.96 for a permanent partial disability advance. The Issues on Review are whether Petitioner is entitled to prospective medical expenses and temporary total disability benefits. The Commission, upon reviewing the entire record, modifies the Arbitrator's decision and finds Petitioner's left hip condition is causally related to the May 10, 2015 work accident and Respondent is to pay all reasonable and necessary cost related to the proposed prospective left hip surgery. Additionally the Commission finds Petitioner was temporarily totally disabled from May 11, 2015 through May 3, 2016 under Section 19(b) of the Act. Lastly, the Commission finds that this case should be remanded to the Arbitrator for further proceedings pursuant to Thomas v. Industrial Commission, 78 Ill. 2d 327 (1980), for the reasons set forth below.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

17IWCC0055

The Commission finds:

1. Petitioner, a 57 year old truck driver, testified that on May 10, 2015 he was driving a truck with two empty trailers from Minnesota to Illinois when his truck was struck by a passenger vehicle. The vehicle struck the truck's front tire and it wrapped around the front of the truck causing him to steer into a ditch. At that time, his left foot was on the clutch; his other foot was on the brake and both hands were on the steering wheel. Petitioner testified that when he went into the ditch, his body came up in the seat and slammed down bottoming out the air-ride seat in the truck. He had no medical treatment on the scene. He went to the Department of Transportation site where his truck was inspected. From there he drove the truck to Chicago. Upon arriving in Chicago his neck, back and shoulder stiffen up. Petitioner said that because it was a long day he went home to sleep and did not go to an emergency room in Chicago. The next morning, he talked to Chris, the drivers' supervisor. He told him he was sore and wanted to go to the clinic. On the way over to the clinic he called Chris and told him that both of his hips were hurting.

2. Petitioner testified that Dr. Branovacki is his doctor and was his doctor prior to the May 10, 2015 motor vehicle accident. In September of 2011, Dr. Branovacki performed surgery on his right hip. He released him back to work 3 months later. Petitioner said he was laid off in early January of 2012 for several weeks but worked from the time he was recalled until the May 10, 2015 motor vehicle accident. From the time he was released after the right hip surgery through May 10, 2015 he was not given any restrictions and he performed his regular duties. In the years leading up to the May 2015 motor vehicle accident, he had no problems or issues with his left hip. During this time, he followed up with Dr. Branovacki for his right hip condition. The follow up visits were at first scheduled semi-annually and later they were annually. As part of the follow up, Dr. Branovacki would examine both hips. Petitioner testified that in 2013 he told Dr. Branovacki that he felt some discomfort/stiffness in his left hip when the weather got severe. He denied that prior to May 10, 2015 that his left hip symptoms affected his ability to perform his full job duties. Also, prior to May 10, 2015, he was never issued an order or restriction at work due to his left hip condition.

3. Petitioner's medical records show that on June 27, 2011 he saw Dr. Branovacki at Midwest Orthopedics. At that time, the doctor noted that Petitioner's physical examination showed that Petitioner's left hip had some mild stiffness and his left hip x-ray showed moderate arthritis while his right hip showed severe arthritis. As a result, Dr. Branovacki prescribed surgery consisting of a right hip resurfacing. Said surgery took place on September 20, 2011.

4. During a June 7, 2012 follow up visit with Dr. Branovacki, the doctor noted that it has been nine months since his right hip surgery. Petitioner reported he loves the result and he has no pain. Petitioner also noted that his left hip is bothering him. Petitioner reports

he is taking Relafen and it helps. On examination, Dr. Branovacki found that Petitioner's left hip is somewhat stiff with mild discomfort at extreme range of motion. Dr. Branovacki indicated that he would see Petitioner back in three to four months on the anniversary of his right hip surgery and at that time he would obtain some x-rays of both hips.

5. On September 27, 2012, Petitioner returned to Dr. Branovacki and reported his left hip has some mild discomfort, stiffness with his left hip rotation and slight weakness compared to his right hip. Petitioner's left hip x-ray showed mild arthritis. Petitioner was treated with anti-inflammatories and antibiotics for prophylaxis.

6. During a June 24, 2013 follow up visit with Dr. Branovacki, Petitioner reported his left hip is causing him some severe pain. He can feel weather changes especially when a rainstorm is coming and it has been getting worse. Dr. Branovacki examined Petitioner and found that his left hip shows some stiffness on rotation, which causes severe pain but he has fairly good range of motion with hip flexion and internal and external rotation. He also has a negative straight leg raise. Dr. Branovacki noted that neurovascularly he is intact, has no calf tenderness and no trochanteric tenderness to palpation. Petitioner's left hip x-ray shows some osteoarthritis with bone-on-bone disease and mild to moderate bone spurs and joint space collapse. Dr. Branovacki recommend some more Relafen and he stated that at some point, he may require a left hip resurfacing to give him a matching set to his right hip. He indicated at that time that Petitioner should return in three months for a re-evaluation.

7. Petitioner testified that on June 24, 2013 Dr. Branovacki said he had minor arthritis in his left hip and he would be looking at a left hip resurfacing procedure down the road, maybe close to retirement.

8. During the December 15, 2014 follow up visit with Dr. Branovacki, Petitioner reported he had been experiencing some stiffness and discomfort in his left hip with activities and rotation but overall he can tolerate the left hip. Dr. Branovacki noted that Petitioner's left hip has mild arthritic changes with bone-on-bone femoral head joint space narrowing. Dr. Branovacki noted that he recommended Petitioner continue with his home exercise program and take some Relafen for his pain. He further stated that he would see the Petitioner back in two years on or around the anniversary of his surgery. Petitioner was also given an off work slip for December 14, 2014 through December 15, 2014.

9. On January 1, 2015, Petitioner testified he was involved in a single motor vehicle accident where the back trailer flipped over. As a result of the accident, he jolted and twisted his right shoulder and neck forward. He did not injury his left hip at that time. Petitioner said that other than taking a couple of days off in January for his neck after the January 1, 2015 motor vehicle accident, he was able to work his full, unrestricted duties in the 3-4 months leading up to May 10, 2015.

10. Petitioner said the last time he saw Dr. Branovacki prior to May 10, 2015 was in December of 2014. He said at that time his left hip was doing all right. It got a little stiff with a bit of weather but it was not exacerbated/aggravated by the January 10, 2015 motor vehicle accident.

11. On May 10, 2015, Petitioner was involved in the above mentioned work accident. Petitioner said he told Mr. Phillip Scoggins after the motor vehicle accident on May 10, 2015 that both of his hips hurt as well as his neck and back and he had a severe headache.

12. The May 11, 2015 employer's investigation report notes that Petitioner indicated that he injured and/or medically treated for stiff middle and lower back pain and for his neck.

13. Petitioner testified that on May 11, 2015 he was seen at Midwest Orthopedics. At that time, he completed a sheet saying his neck, middle, low back and hips were hurting him. When they touched his left hip, he screamed in pain. There was a discussion about an injection to the hip but it was not given at that time.

14. Randall Gaugh testified he is a dispatcher for Respondent. He stated that Petitioner called in an accident. He had him complete an incident report at the end of his trip. The incident report is dated May 11, 2015. At that time, Petitioner completed the report he did not complain of left hip pain. He complained of overall stiffness in his neck, middle and low back.

15. On May 11, 2015, Petitioner saw Physician Assistant Prokop who noted that Petitioner is here after a motor vehicle accident which occurred on May 10, 2015. At the time Petitioner was restrained as a driver and no airbags were deployed. Petitioner reported that his truck was "T-boned" and he slid down into a ditch. He did not rollover, but the accident did cause him to bounce around vehicle. He reported that he was able to drive back to Illinois, but over last ten hours he has been experiencing more and more discomfort. He reported that he has neck pain predominantly on left side. His right hand side feels very stiff. He had some headaches and low back discomfort. He has felt some twitching in his right hip, which started this morning. Prior to that he experienced a dull discomfort and now he is experiencing some twitching and occasionally stabling through the groin whenever he exerts movement to flex or extend the hip. Physician Assistant Prokop also noted that Petitioner's left hip shows severe bone on bone degenerative changes with osteophytes present. He diagnosed Petitioner as having a cervical and lumbar strain without any radicular symptoms, tendinitis and a possible strain of hip. He prescribed physical therapy, medication and told Petitioner to return for a recheck in two weeks and for a re-evaluation of his hips. He also noted that he would possibly give a cortisone injection for Petitioner's left hip if it is still giving him problems. Lastly he took Petitioner off of work. (The Commission notes that while Petitioner did not provide a history of a left hip injury and the records do not show that a physical examination was

performed on the left hip, x-rays were taken for both hips, a diagnosis was made as to the hip which did not specify the right or left side, and a comment was made that the physician assistant will see Petitioner back for a re-evaluation of (both) his hips. Lastly, there was a comment made regarding possibly providing a cortisone injection for the left hip.

16. On May 13, 2015, Petitioner provided a recorded statement to Phillip Scoggins, who is with Respondent's insurance company. At that time, Petitioner stated both hips were bothering him; he also attributed the left hip pain to possible his pre-existing arthritic condition. Excerpts from the recorded statement are as follows:

    Were you recently injured on the job?

    It was on May 10, 2015. I knew I was a little bit sore, but I did not know the immediate ramifications of it until I got up the next day.

    What happened to your body inside the cab?

    It jumbled around pretty good and a couple of things hit me…I took some pretty good bumps going into the ditch. When I woke up my low back was very sore…above the belt line. My neck is sore when I move it from side to side…my hip, both my hips were hurting me. My right hip has a device in it. I'm thinking to myself, if my right hip is twitching even more while driving am I'm going to see this physician again?. I'm thinking is there something wrong with my device. They said they didn't see any breakage in the device. I was getting shooting pain there.

    Is your left hip still hurting you also?

    Yes. It does, but that could be also because I have a lot of arthritis in my body according to my doctors.

17. On May 23, 2015, Petitioner followed up at Midwest Orthopedics with Nurse Practitioner Hager and he did not mention his left hip. On June 2, 2015, Petitioner completed a pain drawing for Dr. Lim at Midwest Orthopedics. The pain drawing shows pain in the left side of his low back but not his left hip. Dr. Lim noted that the only thing that seems to bother Petitioner now is his low back pain. Dr. Lim noted that Petitioner is experiencing a flare-up of the pain in his left groin, which is consistent with his known osteoarthritis of his hip. On physical examination of his left lower extremity, there is no joint enlargement or tenderness. The range of motion of his hip is normal and he had a normal neurological exam.

18. On June 4, 2015, Petitioner followed up with Dr. Branovacki who noted that he had seen Petitioner two times in past month as a result of a motor vehicle accident. He noted that

Petitioner suffered a left hip injury and that his left hip has been bothering him. The pain is in his buttocks. It goes into his groin and it is worse with a startup. Dr. Branovacki noted that Petitioner did not really have any hip problems at his last visit six months ago. He has known pre-existing hip arthritis, but it did not really cause him any symptoms at that time. His left hip x-rays show moderate arthritic changes with joint space narrowing, osteophytes and areas of bone-on-bone disease. Dr. Branovacki recommended a left hip cortisone shot. He stated that he did not want Petitioner working with his left hip for the next month but noted that they could probably release him to work in one month, depending on how his hip feels. Dr. Branovacki noted that if Petitioner's pain persists, Petitioner will likely need to have a left hip resurfacing versus a replacement at some point in the near future.

19. On July 2, 2015, Petitioner followed up with Dr. Branovacki who noted that he had given Petitioner a hip cortisone shot which Petitioner said helped him for one week. Petitioner reported that after the injection he was better but he was not normal

Dr. Branovacki noted that on physical examination Petitioner walked with a slightly antalgic gait favoring his left hip. His left hip had stiffness. His rotation was decreased because of the groin pain that he has suffered since his accident. He has weakness with hip flexion. He has a weakly positive Trendelenburg sign.

Dr. Branovacki noted that Petitioner is receiving physical therapy for his neck and low back. He noted that at this time Petitioner could do some gentle hip therapy as well. He noted that Petitioner was instructed to stay off of work for one more month in order to let his hip rest. Then he can hopefully return to work without any restrictions. Petitioner was instructed by Dr. Branovacki to return for a recheck in one month. He noted that if at that time, Petitioner has not improved they should consider surgery in the form of a left hip replacement or resurfacing surgery.

Dr. Branovacki noted as to the question of causality, Petitioner has had pre-existing left hip osteoarthritis. The x-rays have not changed in four years. Dr. Branovacki noted that Petitioner was asymptomatic with the left hip prior to his May 10, 2015 work injury. Dr. Branovacki testified that he opined that Petitioner's work injury exacerbated a pre-existing condition and has led to a need for further treatment. The x-ray report shows there are degenerative changes in the left hip that are moderately advanced.

20. On July 10, 2015, Dr. Lim, who had been treating Petitioner for his neck and back problems, discharged him from his care. At that time, Dr. Lim noted that Petitioner's biggest problems seem to be associated with his lower extremity, for which he has seen Dr. Branovacki. Lastly, he noted that in terms of his cervical condition, there are no restrictions remaining.

21. On July 30, 2015, Petitioner followed up with Dr. Branovacki who noted that his left hip pain persists. It is in his groin and is worse with activity. On physical examination, his left hip has severe stiffness to rotation. He has weakness to hip flexion. He walks with antalgic gait favoring his left leg. Dr. Branovacki recommended left hip resurfacing surgery at some point in the near future. Dr. Branovacki commented that it is getting to the point where Petitioner cannot work because of his left hip and it is affecting his activities of daily living.

    Dr. Branovacki noted that Petitioner asked him about causality in regard to his left hip condition and his work injury and he responded that he believed that there is causality. He based his belief on the fact that Petitioner had no prior left hip pain before his May 10, 2015 work accident. He opined that Petitioner's current medical condition and necessary treatment are related to his work injury. Lastly, he said he would recommend a left hip resurfacing be done sooner rather than later so as to avoid any unnecessary pain and suffering.

22. On September 10, 2015, Dr. Branovacki noted that Petitioner has been having left hip pain ever since he got injured at work. He recently has arthritis in that hip which was aggravated by the work accident and currently he requires hip replacement surgery as he cannot work due to the constant pain. Dr. Branovacki noted that the cortisone shot that Petitioner was given a few months ago helped him for about three weeks and then it wore off. Petitioner is not due for another injection until December. His exam is unchanged. He still has a limp favoring his left leg. He has stiffness in the left hip with rotation. Weather changes affect him and he has been suffering a lot. He can only sit around. He cannot even stay active to keep his health up.

23. On March 21, 2016, Petitioner amended his Application for Adjustment of Claim to include his back, hips and neck as being injured as a result of the May 10, 2015 work injury.

24. Surveillance was conducted on Petitioner. On May 24, 2015 and June 30, 2015, Petitioner walked normally. On January 2, 2016 and January 31, 2016, Petitioner walked while demonstrating an apparent altered gait. On March 21, 2016 it was noted that Petitioner stepped out at 12:15 p.m. He ambulated while demonstrating apparent discomfort. He was walking with an obviously altered gait. At 1:13 p.m. it was noted that Petitioner was walking with cane and demonstrating an altered gait. On March 24, 2016, it was noted that Petitioner was walked across parking lot and into a store while using a cane. On March 21, 2016 at 12:15 p.m. Petitioner ambulated while demonstrating apparent discomfort and he walked with an obviously alter gait. At 1:13 p.m., Petitioner was using cane in left hand and he demonstrated an altered gait. He was seen loading a truck with a ladder and drywall. He was using his right hand while continually utilizing a cane in his left hand; Petitioner again used a cane at 1:47 p.m.; On March 24, 2016, Petitioner was utilizing a cane and demonstrating an obviously altered gait.

25. Dr. Branovacki, a board certified orthopedic surgeon, was deposed on January 14, 2016. He testified he has a specialty in hip and knee reconstruction. He acknowledged that Petitioner had some left hip arthritis at the time he performed his right hip surgery in 2011 but his left hip was not bothering him.

After the May 10, 2015 motor vehicle accident, Petitioner started having left hip pain and since then he's been having stiffness in the hip, has been limping, and has pain with activity and pain that wakes him up at night. In general, he has a poor quality of life and he reports nothing helps him. His narcotics do not seem to help him.

Dr. Branovacki was asked if he had an opinion of whether the May 10, 2015 collision caused Petitioner's current symptomology. In response, Dr. Branovacki stated that Petitioner did not have any prior issues with his left hip except for some stiffness which did not bother him or cause him to seek treatment. After the May 10, 2015 work accident, Petitioner was checked on over the next six months. His condition just got worse and it came to the point where nothing seemed to help him and he could not do his job or lead an active life. When Dr. Branovacki was asked whether he had an opinion as to whether or not the symptomology in Petitioner's left hip relating to the May 10, 2015 motor vehicle accident was the cause of his inability to work, Dr. Branovacki answered yes. He further stated that the combination of his hip arthritis and the May 10, 2015 accident exacerbating that condition and it led to him not being able to perform his job at this time. He said currently he has recommended that a hip resurfacing take place. When asked if the surgery would be at least in part to treat the symptoms related to the May 10, 2015 motor vehicle accident, Dr. Branovacki answered yes and further stated that there is a causal relationship between the May 10, 2015 motor vehicle accident and his recommendation for the left hip resurfacing surgery. Dr. Branovacki stated that he based his opinion on the fact that after Petitioner's 2011 right hip resurfacing surgery Petitioner was able to return to full duty work. Furthermore, he was able to work full duty without any restriction or problems all the way up to the May 10, 2015 work accident.

When Dr. Branovacki was asked about Dr. Neal, who evaluated Petitioner, he stated that Dr. Neal is a hand surgeon and in his opinion he is not qualified to comment on the hip condition or a specialized procedure that only a handful of us perform. He remembers looking Dr. Neal up on the Internet and concluding that he was not qualified to render an opinion on Petitioner's hip condition. He does not recall if he looked at Dr. Neal's evaluation report.

On cross-examination, Dr. Branovacki agreed that Petitioner's left hip was symptomatic between June of 2013 and December 15, 2014. He also agreed that at the initial evaluation after the May 11, 2015 motor vehicle accident Petitioner did not complain about his left hip and there was not a physical exam of his left hip. However, toward the end of the assessment the physician assistant stated that he will see Petitioner

back in two weeks for an evaluation of his hips and possibly do a cortisone injection for his left hip which is still giving him problems. So, I assumed, that Petitioner said his hip was bothering him but while it was not documented in the history and exam, the plan mentioned that. So, in his mind there was some left hip involvement on that date. He opined that there was probably a physical exam, but the left hip condition just was not documented. He noted that in terms of hip problems, doctors tend to examine both sides for everything.

Dr. Branovacki stated his guess is that he should have said Petitioner was minimally symptomatic rather than asymptomatic prior to the motor vehicle accident. He would disagree with the statement that besides Petitioner's symptoms there was no other evidence that there was an aggravation of his pre-existing condition. He based his statement on the fact that when he rotated Petitioner's left hip, Petitioner screamed in pain. He jumped off the table and said it hurt. This is in contrast to his examination in 2014 when Petitioner had some stiffness and discomfort with activities, but overall, he could tolerate his left hip. While he may not have documented this in his record, he opined that Petitioner was symptomatically worse after the motor vehicle accident rather than before. If it was before the motor vehicle accident, he would have had him do the surgery at some point down the line, but prior to May 10, 2015, he did not believe Petitioner needed to have surgery at that point. After the motor vehicle accident, we tried a shot, various creams, anti-inflammatories and then finally said you are in too much pain so you need to just get the surgery and move on with your life. Dr. Branovacki said at the time he composed his causation opinion, he was unaware of Petitioner being involved in any other motor vehicle accident in January of 2015. When he saw Petitioner prior to the May 10, 2015 motor vehicle accident, he does not remember Petitioner ever talking about his left hip being a big deal. They always focused on the right hip. Petitioner reported that the left hip hurt but it was okay. So he did not think of the left hip as being very symptomatic. Things changed after the May 10, 2015 motor vehicle accident, so he changed his opinion as to how he was going to proceed medically. He agreed that in June of 2013 Petitioner reported severe left hip pain. He believes that at that time Petitioner was experiencing a flare-up of arthritis. He said at that time that at some point he would need surgery but hopefully the flare-up would get better. He agreed that the same surgical procedure is being proposed. His opinion was that before the work accident Petitioner was able to tolerate his hip arthritis and that one day he would need a resurfacing. After the May 10, 2015 work accident, it moved the timeline up to the point where he needed to undergo the surgery sooner than had previously been recommended.

26. Dr. Neal, a board certified orthopedic surgeon, was deposed on March 29, 2016. He is a general orthopedic surgeon with a fellowship in hand and upper extremity although he does not limit himself to those areas. He treats upper extremity, lower extremity the spine and hips, both surgical and non-surgical. He would estimate that 5-10% of his practice is devoted to seeing patients with hip problems. He performed one total hip replacement since the 1st of the year. In the last couple of years he has averaged 5 to 10 hip

replacements a year. He evaluated Petitioner on July 1, 2015. He cannot say that the left hip injection was necessary. As a rule, you do not inject the hip in an office because to inject the inside of the hip joint you have to have an x-ray to confirm the location. Obtaining Petitioner's history was more difficult than average in that Petitioner had a tendency to be very verbal and frequently non-responsive. He reported his symptoms which were broken down to his neck, low back, right and left hips. He described left hip pain in the joint anteriorly, posteriorly and left-sided groin pain. He has left hip stiffness, which is a classic arthritic complaint. He reported his left hip was good prior to May 10, 2015. He admitted it was starting to get a little stiff but it was not painful. He denied left hip pain but stated he had left hip stiffness so he admitted to some pre May 10, 2015 hip arthritic symptomatology. He was of the opinion that there was a tremendous difference in his left hip pre and post May 10, 2015 and the left hip pain prior to May 10, 2015 was noted to vary between 0 to 1 on the pain scale but over the 2 weeks prior to his evaluation it was a 5 to 6 out of a 10 point pain scale. On physical examination his left hip was a little bit longer than the right hip, which appeared to be principally from his prior right hip arthroplasty. His left hip had 20 degrees of external rotation and 10 degrees of internal rotation, which is diminished. It would be consistent with bone-on-bone full thickness advanced arthritis he had on x-rays and it was painful at the extreme range of motion. He diagnosed left hip osteoarthritis. He did not find any significant condition that was related to the May 10, 2015 work accident. Petitioner has severe advanced left hip osteoarthritis, which was undoubtedly pre-existing and it was known to be symptomatic prior to May 10, 2015. There did not seem to be any definitive injury to the hip. He had symptoms before and he would expect Petitioner to have symptoms afterwards. So, Petitioner current left hip condition when he saw him was not related to the May 10, 2015 events and he believes it was principally related to Petitioner's pre-existing osteoarthritis. The mechanism of injury would not have caused left hip arthritis. The left hip osteoarthritis would have taken years to develop. Even if he had fractured his hip it would have taken months for a fracture to impair the blood flow and to lead to a complete loss of articular cartilage degeneration. He does not believe that the May 10, 2015 event had any permanent worsening of his hip condition. There was no injury that further advanced the arthritis. Arthritis is a painful process. Petitioner admitted pain prior to May 10, 2015. He would expect that the significant majority of people with bone-on-bone articulation would be symptomatic to some degree prior to May 10, 2015 and that would continue afterwards, but he cannot find evidence that there was a permanent worsening of Petitioner's advanced arthritis condition prior to May 10, 2015. He required no left hip treatment as a result of the May 10, 2015 event. He was driving with full thickness bone-on-bone arthritis prior to May 10, 2015 and he would be able to drive his truck with bone-on-bone full thickness cartilage loss and advanced arthritis after May 10, 2015. At the time of his exam, he found Petitioner could return to full duty work. He was not specifically asked to comment about Petitioner's left hip condition prior to his examination of Petitioner. However, since Petitioner submitted this was an anatomic area of involvement, he was asking a lot of questions. He was not provided with any medical records showing treatment rendered prior to May 10, 2015.The first record he has is from

June 2, 2015. Dr. Neal was given a hypothetical that based on the history contained in Petitioner's PX1 and specifically the manner in which Petitioner's body moved during the course of this incident would he be able to say whether that type of mechanism of injury could trigger symptoms in a previously asymptomatic arthritic left hip and Dr. Neal answered no. Specifically, he said that based on Petitioner's history and the mechanism of injury it could not be the case. If one reads Petitioner's entire history section, Petitioner never points out that he had any left hip pain. So if the history is accurate, Petitioner does not have left hip pain. In order to determine if the left hip condition has progressed he needs to look both at what the examinee states and the medical records. He noted that comparison of the x-rays before and after may or may not help depending on when they were taken in relationship to the time of the incident. The only person that will determine if he needs a hip replacement will be the Petitioner, himself. Dr. Neal said he cannot state Petitioner's medical records indicated unequivocally that Petitioner was asymptomatic and Petitioner did not tell him his left hip was asymptomatic during his history.

27. Petitioner testified he has not worked since May 10, 2015. In driving a truck, he needs to takes breaks to void his bladder and to stretch out. Sitting too long causes pain in his feet. He has to use both feet to operate the semi-tractor and to enter/exit the tractor. He has to physically manipulate the 2,500 converter dolly to join the trailers. At times, the equipment is rusted and hard to operate. Currently, he is unable to drive the truck. He does not have a current medical card or a release from his doctor to return to work. He has not driven more than an hour anywhere since he was off of work on May 10, 2015. If he were to drive longer, his left hip would hurt, cramp and ache. When he engages the clutch with his left foot, it requires a certain amount of force/pressure. The pedal tension on some trucks is more than other. When he performs forward movement there is an area in his left hip that causes pain, weakness and loss of strength. When he is in his personal vehicle, potholes, railroad tracks are jarring and cause him discomfort.

The Commission finds that none of the parties is disputing that Petitioner has a pre-existing bone-on-bone arthritic left hip condition leading up to the May 10, 2015 work accident. The primary question is whether Petitioner's left hip was asymptomatic and/or only mildly symptomatic prior to the May 10, 2015 work accident and whether the May 10, 2015 work accident caused an aggravation/exacerbation of the asymptomatic/mildly symptomatic condition that took it from the pre-accident state of watching the condition with the understanding that there is a need for a proposed surgery "at some point" to the need to undergo more imminent surgery in the near future.

The Commission finds that while diagnoses do not specifically address the left hip condition, there is some evidence in the month after Petitioner's May 10, 2015 work accident that he was experiencing problems related to his left hip condition and/or the need for treatment of the same. There is no doubt on the day after the accident that Petitioner did not list his left hip as an injured body part on his accident report. There is

also at best a mixed bag presented by Physician Assistant Prokop who does not take down a history of a left hip injury, does not record a physical examination took place in regard to the left hip and provides a nonspecific diagnosis of a possible strain of the hip without specifying whether it is the right or left hip, but yet who also takes a left hip x-ray, indicates that Petitioner is to return for a re-evaluation of both his hips and further indicates that there is a possibility that a cortisone injection will be needed for the left hip in the future if it is still giving Petitioner problems. Unfortunately, the Commission finds that the Arbitrator's decision only addresses a portion of this medical entry while not addressing the other portion, which in turn leads the reader to believe that there was no mention of the left hip whatsoever.

In reviewing the evidence anew, the Commission finds that while the primary treatment focus was obviously not placed on the left hip that day, the evidence allows for an inference to be drawn by the Commission that Petitioner was having some left hip issues immediately after the May 10, 2015 work accident. Petitioner's testimony at arbitration and his recorded statement taken three days after the May 10, 2015 work accident further supports the fact that Petitioner was experiencing some left hip pain shortly after the May 10, 2015 work accident. It is additionally supported again three weeks later when Dr. Lim indicates that Petitioner's left groin flare-up pain is consistent with his known osteoarthritis of his hip.

When Petitioner is seen by a hip specialist who happens to have also previously treated Petitioner's right hip condition, he relays a left hip pain that goes into his buttock and groin area. Since Dr. Branovacki is well versed in Petitioner's current and prior treatment and Petitioner's ability to perform variously activities such as working full time he is able to compare and contrast Petitioner's left hip condition both prior to and after the May 10, 2015 work accident. More specifically, Dr. Branovacki is able to comment that Petitioner had not really had any hip problems when he saw him six months ago. Specifically, he indicated on December 15, 2014 that while Petitioner had bone-on-bone arthritis in the left hip he was able to tolerate his stiffness and discomfort with activities at that time and all he was in need of was conservative treatment via home exercises and pain medication.

While it is true that Dr. Branovacki indicates in his June 24, 2013 medical entry that predates the work accident by approximately two years that "at some point" Petitioner would be a candidate for left hip surgery, Dr. Branovacki is still content on December 15, 2014, a year and a half later and in the last visit leading up to May 10, 2015, to find that Petitioner is not in need of more than conservative treatment for his left hip condition.

Fast forwarding to June 4, 2015 again, Dr. Branovacki is again conditionally talking about the "likely" need of left hip surgery at some point in the "near" future if Petitioner's pain persist. Again, unfortunately, the Arbitrator's decision does not provide

as detailed an account of what occurred during the June 4, 2015 medical visit and specifically what Dr. Branovack's thoughts were at that time. Subsequently, Dr. Branovack consistently holds the opinion that Petitioner's left hip condition has worsened and requires more medical attention than in the past. This is specifically reflected in the July 2, 2015 medical entry where Dr. Branovacki notes that Petitioner's work injury exacerbated Petitioner's pre-existing asymptomatic condition and has resulted in a need for additional treatment. He also reclassifies Petitioner's degenerative condition from being previously "mild" to now being "moderate" in nature.

Shortly thereafter, Dr. Branovacki notes on July 30, 2015 that Petitioner's left hip pain not only persiss but that his groin pain is worse with activity as is his range of motion, strength and gait on physical examination. Again, at this point he reclassifies Petitioner's need for surgery from that of "at some point" to "some point in the near future" and he comments that it is getting to the point that Petitioner's left hip condition is causing him to be unable to work and is affecting daily living activities. When Dr. Branovacki is asked by Petitioner if this is related to his most recent work accident he answers in the affirmative. He further expounds on this in his deposition when he indicates that he exhausted all conservative methods of treatment and he advised Petitioner due to his being in "too much pain" he should get surgery and then move on with his life.

Reviewing the totality of Dr. Branovacki's body of work, it does not appear that he flippantly advised Petitioner to have surgery or that he had not exhausted all conservative means prior to pulling the trigger and advising surgery. Furthermore, having been Petitioner's treater for quite some time both prior to and after the May 10, 2015 accident and have established his hip specialty led him to be well versed in such conditions, the Commission finds that the Arbitrator erred in not acknowledging Dr. Branovacki's expertise and past history with the Petitioner and by not placing a lot of weight on his causation opinion.

Contrasting Dr. Branovacki's expertise, experience and thorough understanding of the case to that of Dr. Neal, a one-time evaluator with a very limited expertise in the treatment of hip problems who was not provided with Petitioner's medical records leading up to the May 10, 2015 date of accident, would be to commit an injustice in this case. Dr. Branovacki hands down has a greater breath of understanding of Petitioner's medical situation than does Dr. Neal. As such, the Commission reverses the Arbitrator and finds both causation and the need for the prospective left hip surgery in the case at bar. The Commission further finds that Petitioner has not reached maximum medical improvement and he is entitled to temporary total disability benefits from May 11, 2015 through May 3, 2016.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $1,067.93 per week for a period of 51-2/7 weeks, that being the

17IWCC0055

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 all reasonable and necessary medical expenses for the proposed prospective left hip surgery under §8(a) of the Act.

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

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

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit in the amount of $8,599.28 for payment of temporary total disability benefits and $5,882.96 for a permanent partial disability advance paid to or on behalf of Petitioner on account of said accidental injury.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $40,400.00. 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.

JAN 3 1 2017

DATED:

MB/jm

O: 12/15/16

43

Mario Basurto

David L. Gore

Stephen Mathis

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

Leah Roman,
Petitioner,
vs.

UIC Police Department,
Respondent,

NO: 12 WC 01518

17IWCC0056

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, 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 March 28, 2016, is hereby affirmed and adopted.

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

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

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

DATED: JAN 3 1 2017
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DLG/mw
045

David L. Gore

Stephen Mathis

Mario Basurto

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ROMAN, LEAH
Employee/Petitioner

Case# **12WC001518**

UIC POLICE DEPARTMENT
Employer/Respondent

17IWCC0056

On 3/28/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.44% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2559 BOWMAN & CORDAY LTED
LANA ALLAN CORDAY
134 N LASALLE ST SUITE 1440
CHICAGO, IL 60602

0264 HEYL ROYSTER VOELKER & ALLEN
DANA HUGHES
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PEORIA, IL 61601-6199

L. Roman v. UIC PD , 12 WC 01518

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

Leah M. Roman
Employee/Petitioner

v.

UIC Police Department
Employer/Respondent

Case # 12 WC 01518

17IWCC0056

An Application for Adjustment of Claim was filed in this matter, and a Notice of Hearing was mailed to each party. The matter was heard by the Honorable **Jeffrey Huebsch**, Arbitrator of the Commission, in the city of **Chicago**, on **December 14, 2015 and January 12, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [ ] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [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. [x] Other **Section 5(b) lien credit**

17IWCC0056

FINDINGS

On **October 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 **$53,748.24**; the average weekly wage was **$1,033.62**.

On the date of accident, Petitioner was **25** years of age, ***single*** with **0** dependent children.

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

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

The Parties agreed that all TTD and TPD payments due have been paid by Respondent.

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of **$620.17/week** for **35 weeks**, because the injuries sustained caused the **7% loss of the person as a whole**, as provided in **Section 8(d)2 of the Act.**

Respondent shall pay Petitioner **reasonable and necessary medical services** of **$4,757.61**, as provided in **Sections 8(a) and 8.2 of the Act.**

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

Respondent shall be entitled to credit in the amount of **$3,894.36** for its **Section 5(b) lien credit.**

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

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

March 28, 2016
Date

MAR 2 8 2016

FINDINGS OF FACT

Petitioner was employed by Respondent as a police officer. The Parties stipulated that Petitioner sustained accidental injuries which arose out of and in the course of her employment by Respondent on October 22, 2011. On that date, she was involved in a serious vehicular collision, when the patrol car that she was riding in was struck by another vehicle. The patrol car was significantly damaged (PetEx.1-a,b,c) Petitioner was sitting in the front passenger seat. She had to be extricated from the vehicle by "jaws of life" and was taken by ambulance to Stroger Hospital.

Petitioner was admitted to Stroger Hospital for three days, October 22-24, 2011, undergoing diagnostic tests and observation. She had complaints of neck pain, left arm pain, numbness and weakness, right elbow pain, back pain, upper leg pain, right elbow pain and multiple bruises. The diagnosis was cervical cord concussion (sic) and she was discharged with a cervical collar and advised to avoid heavy lifting and quick movements of the neck, and no driving while taking narcotic medication. She was referred to her primary care physician for follow up. (PetEx. 4)

Petitioner was initially seen by Dr. Pamela Strauss, of Rush Associates Internal Medicine, on October 26, 2011 and complained that everything hurts, lots of bruises, with tingling in the left hand. Dr. Strauss diagnosed lumbar strain, cervical strain and chest wall muscle strain. Physical therapy and medication was prescribed. Petitioner saw Dr. Strauss for follow-up on November 8, November 22, December 6, December 20, 2011 and January 23 and February 27, 2012. On November 22, 2011, Dr. Strauss referred Petitioner to Dr. Sheila Dugan of Rush University Neurosurgery. (PetEx. 6)

Petitioner initially saw Dr. Dugan on December 2, 2011, with diagnosis of myofascial pain/whiplash after work related MVC. Medication, physical therapy and work restrictions were prescribed. Petitioner was next seen on January 9, 2012, complaining of neck and back pain. Bilateral cervical trigger point injections were performed by Dr. Dugan. Petitioner continued to see Dr. Dugan on January 25, February 13 and on March 5, 2012 when she again underwent

cervical trigger point injections for persistent neck pain. She was seen again by Dr. Dugan on March 23, 2012 and released from care on June 13, 2012 with the diagnosis of myofascial pain, and was instructed to continue with home exercise program. Dr. Dugan charted that Petitioner was at MMI. (PetEx. 7)

While under the care of Dr. Strauss and Dr. Dugan, Petitioner underwent physical therapy to her cervical and lumbar spine at Sports & Ortho from November 2, 2011 through discharge date of June 6, 2012. (PetEx. 10)

Following her accident, Petitioner was required by Respondent to be seen for evaluation on a regular basis at UIC University Health Service from November 1, 2011 through June 13, 2012. The Occupational Nurse Practitioner indicated on June 13, 2012 that Petitioner was released from care and more likely than not, will not require any further treatment for this injury at this time, however, the possibility for chiropractic care and pain management may be needed in the future, per employee report. (PetEx. 5)

While under the care of Dr. Strauss, Dr. Dugan and UIC University Health Service, Petitioner was off work from October 23 to December 19, 2011 and released to sedentary work four hours/day from December 21, 2011 to February 13, 2012, and sedentary work for eight hours/day from February 13, 2012 to March 23, 2012. Petitioner was released to full duty activities as a police officer on March 24, 2012. (PetEx.3) The Parties agreed that all TTD and TPD benefits owed were paid by Respondent.

After working full duty for approximately 2-1/2 months, on June 18, 2012, Petitioner sought medical attention from pain management specialist, Dr. Baljinder Bathla of Chicago Sports and Spine. Petitioner's major complaint was cervical spine pain and the diagnosis was cervicalgia and cervical radiculopathy. Petitioner attended physical therapy and underwent cervical epidural steroid injections on July 30, 2012 and September 19, 2012, with relief of neck pain after her injections. A cervical MRI done on July 20, 2012 showed multi-level degenerative disc disease. The cervical EMG/NCV study of June 21, 2012 was largely unremarkable. Petitioner continued treating with Dr. Bathla for cervical spine complaints through October 15,

2012. She was seen for low back pain and trochanteric bursitis on December 7, 2012. She said that her cervical condition was well and she related a long history of low back pain. (PetEx. 11)

On March 11, 2014, Petitioner was evaluated by Dr. Jeffrey Coe, a Board Certified Occupational Medicine Specialist. Dr. Coe's deposition was taken on February 9, 2015. He testified that he diagnosed Petitioner with a cervical sprain/strain and a lumber strain. Petitioner has residual neck pain, neck stiffness, some upper extremity radiculopathy and some low back discomfort as a result of the accident. Dr. Coe opined that the treatment that Petitioner received, including the injections and the treatment by Dr. Bathla after Dr. Dugan found her to be at MMI, was reasonable and necessary to cure or relieve the effects of the injury. Dr. Coe was unaware of any prior treatment that Petitioner had received for low back complaints. He was not aware of Petitioner having an increase in back symptoms after bending over to put on shoes at Kohl's in January of 2012. (PetEx.12)

On May 27, 2014, Petitioner was examined at Respondent's request by Board Certified Orthopedic Surgeon Dr. Joseph T. Monaco. Dr. Monaco did not review the records of Dr. Bathla. He did review records from Petitioner's PCP which showed prior treatment for low back complaints. It was noted that Petitioner had completed PT and her back pain had resolved as of September 27, 2011. Dr. Monaco thought that Petitioner was at MMI as of June of 2012 and made an AMA Impairment Rating calculation of 0%. (ResEx. 2)

Respondent submitted a Utilization Review Report of December 27, 2011, approving 6 out of 12 requested therapeutic exercises for the low back and 6 of 12 units of manual therapy for the low back. (ResEx. 3)

On cross-examination, Petitioner agreed that she had prior treatment for her low back. She currently is an evidence technician and she makes more money than she did before the accident. She is able to do her job. She is not currently under treatment.

Petitioner testified that she continues to work for Respondent as a patrol officer. On a daily basis, she notices pain in her neck with increased activities, and carrying or lifting heavy

items such as her duty bag, with weapons and equipment. Due to budget cuts, she now rides alone as a patrol officer and, while driving, turning her neck and looking over her shoulder can sometimes be painful. She does not complain to her supervisors, as it is difficult to do so as a female officer in a male dominated field.

She no longer participates in recreational activities such as she did prior to the accident. She no longer does high impact exercises. She has gained weight due to lack of activity. She experiences pain when lifting or carrying her baby daughter. She experiences pain going up and down stairs. She takes aspirin or Tylenol as needed.

Petitioner had a civil case against the driver of the car that struck the car that Petitioner was riding in. The case was settled for $13,333.33. Petitioner's civil lawyer received $4,464.44 of the proceeds. Petitioner received $2,763.25 and Respondent received $6,105.64. (ResEx. 4, PetEx. 18 & 19)

CONCLUSIONS OF LAW

(F) IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY?

Petitioner sustained injuries to her neck and back when involved in a significant motor vehicle collision which required her to be extricated from the patrol vehicle by the "jaws of life". She was admitted to Stroger Hospital for three days immediately following the accident, discharged with a cervical collar, activity restriction and referral to personal physician. Treating physicians, Dr. Strauss and Dr. Dugan diagnosed cervical strain, lumbar strain, chest wall strain and myofascial pain, attributed to the motor vehicle accident. Petitioner received a course of physical therapy at Sports and Ortho from November 2, 2011 through June 6, 2012. UIC University Health Service concurred with the diagnosis. Dr. Bathla attributed Petitioner's cervical problems to the motor vehicle collision.

Dr. Coe opined that there is a causal relationship between Petitioner's motor vehicle accident and the physical condition he found in Petitioner's neck and back injuries. Her subjective complaints of neck pain and stiffness, and some low back pain are consistent with the objective findings (PetEx. 12, pp.36, 37). Dr. Monaco opined that as a result of the work related incident, Petitioner incurred the following diagnoses: mild contusion of the right elbow, resolved; mild contusion of the right hip, resolved; acute cervical strain, resolved; and acute lumbosacral strain, resolved. (ResEx. 2)

Based upon a careful review of the medical records, reports, deposition testimony and Petitioner's credible testimony, the Arbitrator finds that Petitioner's current condition of ill-being as diagnosed by Dr. Coe (neck pain, neck stiffness, some upper extremity radiculopathy and low back discomfort) is causally related to her work related accident of October 22, 2011.

(J) MEDICAL TREATMENT AND EXPENSES AND HOLD HARMLESS FOR GROUP INSURANCE PAYMENTS.

Medical treatment from the onset of the motor vehicle collision of October 22, 2011 through June 13, 2012 was processed through Respondent's Workers' Compensation program. After returning to full duty activities in March 2012, Petitioner continued to experience pain in her cervical spine, though she was released by the initial treating physicians. She sought treatment from Dr. Bathla, a pain management specialist, and underwent additional physical therapy and two cervical epidural steroid injections on July 30, 2012 and October 15, 2012. Medical records indicate relief of pain from those injections (Pet.Ex.No.11, pp. 9, 21). The course of treatment prescribed by Dr. Bathla and the cervical epidural steroid injections were provided to cure or relieve Petitioner from the ill-effects of her injury, and were effective in doing so. It follows that said treatment was necessary and reasonable.

Dr. Coe opined that the injections were necessary and reasonable to cure or relieve the Petitioner from the ill-effects of her injury and all of the treatment rendered from the date of

accident through December 2012 was reasonable and necessary, and necessitated by the accident of October 22, 2011.

Based upon a careful review of the medical records, reports, deposition testimony and Petitioner's credible testimony, the Arbitrator finds that medical treatment provided was reasonable and necessary to cure or relieve the Petitioner from the ill-effects of her injury. Medical expenses associated with the treatment prescribed by Dr. Bathla and Chicago Sports and Spine, and Sports and Ortho through October 18, 2012, are found to be reasonable and necessary. Accordingly, Respondent shall pay Petitioner the following sums:

Sports & Ortho	$315.00	(Pet.Ex.No.13)
Chicago Sports & Spine	$2,560.11	(Pet.Ex.No.14)
Advanced Medical Imaging	$414.58	(Pet.Ex.No.15)
Advanced Medical Imaging	$1,468.00	(Pet.Ex.No.16)

The award of medical expenses is pursuant to §§8(a) and 8.2 of the Act. Respondent is entitled to a credit for all bills paid.

The bills from Chicago Sports & Spine for treatment on December 7, 2012 are not awarded, as this was for low back and hip treatment that the Arbitrator is not persuaded is causally related to the accident.

In accordance with Section 8(j) of the Act, Respondent shall hold Petitioner harmless from claims made by the group health insurance carrier, Cigna (PetEx.17), for payment of medical expenses related to treatment prescribed and performed by Dr. Bathla and Chicago Sports and Spine, and associated providers.

(L) NATURE AND EXTENT OF THE INJURY

Petitioner sustained serious and permanent injuries to her cervical and lumbar spine as a result of the vehicular collision of October 22, 2011. All of the physicians, treating and examining, have diagnosed cervical and lumbar strains resulting from the accident. As a result of her injuries, Petitioner underwent 2 sets of bilateral cervical trigger point injections by Dr. Dugan

and two cervical epidural steroid injections by Dr. Bathla. Petitioner continued to have subjective complaints of pain corroborated by objective findings. Dr. Coe found her symptoms to be consistent throughout the medical records and treatment. She had complaints of neck pain, neck stiffness, and some low back discomfort. Petitioner credibly testified to increased pain in her neck upon increased activities. She has gained weight due to lack of activity. She previously was very active in recreational sport activities. Though experiencing pain at work, she has not voiced complaints to her supervisors. The Arbitrator finds Petitioner's testimony to be credible.

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 in the 8.1(b)(a) report;
- (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 treating medical records.

With regard to paragraph (i) of Section 8.1(b) of the Act:

The report of Dr. Joseph T. Monaco was admitted in evidence. Dr. Monaco finds 0% impairment as a result of Petitioner's neck injury. Dr. Monaco finds 0% impairment as a result of Petitioner's back injury. Impairment is not equated to disability in Illinois. This factor is given some weight in determining PPD.

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

Petitioner continues to be employed as a police officer for Respondent. She testified that she now patrols alone, without a partner, and she experiences pain while driving the patrol car. She has weekly shifts at the psych ward which places her at risk of contact with combative patients. This factor is given some weight in determining PPD.

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

Petitioner was 25 years old on the date of accident, currently 29 years old. The Arbitrator considers her to be a younger individual and concludes that Petitioner's permanent partial disability may be more extensive than that of an older individual, as she will have to live with the disability for a longer period of time. Dr. Coe opined that she would live with the permanent condition for many years. This factor is given more weight in determining PPD.

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

Petitioner's future earning capacity appears to be undiminished as a result of injuries as she has returned to full duty employment. Thus, this factor is given no weight in determining PPD.

With regard to paragraph (v) of Section 8.1(b) of the Act:

Petitioner has demonstrated evidence of disability corroborated by the treating medical records, and the examining physicians as well. Petitioner sustained serious injury requiring cervical bilateral trigger point injections and cervical epidural steroid injections. Her subjective complaints are corroborated by the medical records and reports of Stroger Hospital, Dr. Strauss, Dr. Dugan, Dr. Bathla and the physical therapy providers. Dr. Coe, three years after accident, found tender areas described as trigger points on the posterior cervical musculature, indicative of myofascial pain. He found mild to moderate stiffness in her neck and sensory changes in her right upper extremity, somewhat in the distribution of right C6 nerve root with some C7 and C8 involvement. He found tenderness and stiffness in the low back. Dr. Monaco found slightly limited range of motion of the lumbar spin and discomfort with rotation in the base of the neck area. Petitioner's subjective complaints are supported by the medical records. This factor is given the most weight in determining PPD.

The determination of permanent partial disability ("PPD") is not simply a mathematical calculation, but an evaluation of all five factors as required by the Act. In making this evaluation of PPD, consideration is not given to any single enumerated factor as the sole determinant. Therefore, applying Section 8.1b of the Act, 820 ILCS 305/8.1b, the Petitioner has sustained accidental injuries that caused serious and permanent disability to the cervical and lumbar spine to the extent of 7% in accordance with §8d(2) of the Act.

(O) SECTION 5(b) LIEN CREDIT

As a result of her vehicular accident, Petitioner received a third party civil action settlement in the total amount of $13,333.33. Respondent received payment of its Section 5(b) lien to date in the amount of $6,105.64, leaving a balance of $7,227.69 for Petitioner and her civil attorney, Susan Smith. After deduction of attorney's fees and expenses, Petitioner received the net sum of $2,763.25 as her share of the proceeds from the civil action settlement.

In accordance with Section 5(b) of the Act, Respondent shall be entitled to a credit in the amount of $3,894.36.

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

Lester Sipe,
Petitioner,

vs.

NO: 14 WC 15130

Heuerman Bros., Trucking, LLC,
Respondent,

17IWCC0057

DECISION AND OPINION ON REVIEW

Respondent appeals the decision of Arbitrator Nowak finding that Petitioner sustained an accidental injury arising out of and in the course of his employment on February 15, 2014. As a result Petitioner was temporarily totally disabled from February 15, 2014 through June 3, 2015 for 67-4/7 weeks under Section 8(b) of the Illinois Workers' Compensation Act, is entitled to $13,720.06 in current medical expenses and Respondent is to pay for the prospective medical recommended by Dr. Rerri pursuant to Section 8(a) of the Act. The Issues on Review are whether a causal relationship exists between the February 15, 2014 accident and Petitioner's present condition of ill-being, and if so, the extent of Petitioner's temporary total disability and the amount of reasonable and necessary current medical expenses and whether Petitioner is entitled to prospective medical expenses. The Commission, after considering the entire record, modifies the Arbitrator's decision and finds Petitioner is not credible. Petitioner failed to prove a causal relationship exists between the February 15, 2014 work accident and Petitioner's present condition of ill-being. The Commission finds as a result of the February 15, 2014 work accident Petitioner was temporarily totally disabled from February 16, 2014 through April 23, 2014 at which time he reached maximum medical improvement. The Commission vacates any medical bills after April 23, 2014. The Commission further finds that the April 19, 2014 and April 30, 2014 medical services are not related to the February 15, 2014 accident and it vacates the award for these bills.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

17IWCC0057

The Commission finds;

1. On February 15, 2014, Petitioner, a semi-truck driver, jumped out of his truck slipped, fell and landed on his left side. After that, he experienced a sharp, stabbing, shocking pain in his low back.

2. On February 18, 2014, Petitioner was seen at Bonutti Clinic by Dr. Rudert. Petitioner provided a history of falling on ice last Saturday and landing on his left side injuring his left hip and back. He reported that at that point his pain was not so much in his hip joint as it was in his low back and at times the pain radiated down into his left leg causing it to be numb and tingle. Dr. Ruder noted that on examination Petitioner was uncomfortable when he had to change positions or walk. He was limping and he reported that standing was uncomfortable. The doctor noted that there was not a lot of radicular pain. The pain was mainly over the S1 joint and lumbosacral spine. In a standing position, Petitioner was quite uncomfortable from L1 all the way to the sacrum. Most of his pain was on the left side and in his left hip greater trochanteric region. His buttocks and sciatic notch were also painful. His single leg stance was painful on the left and negative on the right. He could stand on his toes but was quire uncomfortable on his left leg. He was painful with any kind of range of motion or palpation of the sciatic notch. His forward flexion was limited to about 40 degrees. His x-rays showed a degenerative disc at L5-S1. He also has a black disc phenomena at L4/L5 where he looked like he was fused previously, but he does not have any posterior fusion mass on plain film radiography. Dr. Rudert diagnosed low back and left hip pain, degenerative lumbar disc disease and a contusion of the left hip. He took Petitioner off of work, prescribed ice and heat 2-3 times a day. He instructed Petitioner to use crutches and/or a cane and to stay off his hip. He ordered an MRI and scheduled Petitioner for an orthopedic consultation.

3. The March 3, 2014 lumbar MRI demonstrated that a left laminectomy had previously taken place at the L4 level. Currently, Petitioner has degenerative changes at the L4-5 and L5-S1 levels with a mild left-sided neural foraminal compromise at the L5-S1 level.

4. On March 3, 2014, Petitioner followed up with Dr. Rudert who noted that Petitioner still had significant discomfort in the leg which was not getting any better. His MRI showed a prior disc surgery had taken place at the L4-5 level. Currently, he is still experiencing S1 radiculopathy in his left leg. Dr. Rudert diagnosed Petitioner as having degenerative disc disease of the lumbar sacral spine, hip pain, lumbago and radiculopathy. He instructed Petitioner to see Dr. Rerri for an orthopedic spine consultation.

5. On March 10, 2014 Petitioner saw Dr. Ogan at the Illinois Spine and Pain Center. Dr. Ogan noted that Petitioner presented for an evaluation of low back pain with constant radiating pain to left posterior/lateral buttock, thigh and calf along with weakness in left lower extremity. Dr. Ogan opined that Petitioner's stated complaints, physical examination, mechanism of injury and lumbar MRI findings are all consistent with lumbar nerve root irritation on the left at the L4-5 and L5-S1 levels. Dr. Ogan diagnosed low back pain, degeneration of lumbar intervertebral disc, disorder of low back, displacement of lumbar intervertebral disc without myelopathy and lumbosacral radiculitis. He ordered an epidural injection which was given on March 11, 2014 and was administered to the left L4-5 and left L5-S1 levels.

6. On March 14, 2014, Petitioner telephoned Dr. Rudert and reported that the injection he had with Dr. Ogan did not help and his pain is intense and intolerable. Petitioner was told that the doctor was not in that day and he was instructed to go to the emergency room. The same day Petitioner was seen at Cross Roads Hospital's emergency room where he reported that he had fallen approximately one month ago and that the fall had resulted in an injury to left side of his back. He reported that his MRI showed disc disease and that he has been on medication, but it no longer works for his pain. He also reported intermittent numbness and tingling to the lateral aspect of his left thigh. He reported he had had an epidural this last week without any improvement. He rates his current pain as being a 3 out of a possible 10. The doctor noted that his grimacing, guarding, irritable and restless pain behavior was noted to be appropriate. Petitioner was provided with medication and advised to see Dr. Rerri for his pre-scheduled visit.

7. On March 21, 2014, Petitioner saw Dr. Rerri who noted that Petitioner's lumbar MRI showed advance disc degeneration at L4-L5 with over 3 mm of retrolisthesis. He found that the lumbar alignment was kyphotic with apex at L4-L5 but there was no significant compressive lesion. He instructed Petitioner to obtain physical therapy and stated that if this did not provide relief he would offer him a L4-5 transforaminal interbody fusion with the goal to control the pain and address the post-laminectomy instability at L4-5. Dr. Rerri opined that the recent work injury aggravated/ exacerbated Petitioner's pre-existing post-laminectomy problem at L4-5 and because the severe pain has been incapacitating despite supportive treatment, Petitioner will be a likely be a candidate for stabilization by an interbody fusion.

8. On March 25, 2014, Petitioner was seen at Biomax Rehabilitation Services by Physical Therapist VonBehren. The therapist noted that Petitioner's primary diagnoses were radiculopathy, degenerative disc disease of the lumbar sacral spine and lumbago. She noted that Petitioner has tried Prednisone and has been taking pain pills like candy. He reported most of his pain was present in his left lower back and he experienced radicular symptoms in the left leg. He further reported that he has numbness and tingling present throughout the lateral side of the entire leg. The

therapist noted that Petitioner is currently using a straight cane to assist with ambulation. His wife, who accompanied him, stated Petitioner's vertebrae are not in line. She further reported that Dr. Rerri stated Petitioner needs to try physical therapy, but it would ultimately take surgery to improve his symptoms. She also opined that making Petitioner do therapy is only going to make his symptoms worse.

The therapist noted that Petitioner's pain was noted to be very minimal with palpation over his lumbar spine. Petitioner was able to transfer from supline to prone position, but he required increased time, exhibited facial grimacing and reported pain. Petitioner ambulated with a straight cane in left hand. Petitioner displayed a compensated Trendelenburg pattern where he shifted his weight over the left side of his body and onto the cane. On range of motion, he demonstrated moderate restriction with pain on flexion, extension and right and left trunk rotation. He demonstrated minimal restriction and pain with the right and left lateral flexion. His left lower extremity strength was 4-/5 and his left hip extension was 3-/5. He reported his pain was present in left lower back with all MMT on the left lower extremity. Petitioner reported pain in his low back even before a stretch was felt with the left hamstring and piriformis stretch. The Petitioner had intact light touch sensation for lower extremity dermatomes although he reported numbness and tingling being present primarily through the L5-S1 dermatome. The Petitioner had decreased strength present through the left lower extremity, which did not specifically follow any one myotome. At approximately 50 degrees, the Petitioner reported pain was present in the left side low back with straight leg raising. However, he did not report any increase in radicular symptoms. On Waddell testing, he was positive for 3 out of the 5 tests. Specifically, he was positive for simulation, trunk rotation and distraction. Overall, the Petitioner had poor tolerance with the evaluation and specifically when he was asked to perform lumbar range of motion his wife stated "good luck".

Therapist VonBehran noted that the Petitioner was able to perform lumbar range of motion although he had restrictions present and he reported pain with all motions. The Petitioner had decrease strength present throughout the left lower extremity. He also had decreased flexibility present. He had an empty end feel with pain limiting motion rather, than a stretch being felt. He had difficulty with transfers and he required increased time to perform. The Petitioner tested positive for some Waddell signs, which may indicate that there may be symptom magnification present. More specifically, the Petitioner reported pain present with straight leg raising at 50 degrees but he was able to perform the full extended LAQ position without the same report of pain. The Petitioner also reported pain with axial loading and shoulder rotation when these maneuvers should not replicate any painful symptoms. The Petitioner was ambulating with a cane in left hand and he was told that the proper cane placement should be in his right hand. The therapist attempted to have the Petitioner perform hamstring, piriformis, and SKTC stretches as HEP but he reported pain before a stretch was felt. Petitioner's wife stated she thought it was stupid they had to send the

Petitioner for physical therapy. She further stated that it is going to make his symptoms worse, but she understood it was part of getting workers' compensation approval. When Petitioner was asked about therapy, he stated that he would be unable to tolerate therapy.

9. On March 26, 2014, the nurse's telephone note from the Bonutti Clinic indicated Petitioner was to start therapy, but he stated the pain is too bad and he wished to proceed with surgery. Dr. Rerri indicated in a response telephone call that they should start seeking authorization for surgery under workers' compensation.

10. On March 31, 2014, Petitioner was seen at Bonutti Clinic by Physician Assistant Furlong who noted that Petitioner presents today with worsening symptoms of pain and radiating pain down his left leg with numbness and tingling. He stated that as of last night he cannot feel his left foot and he wishes to proceed with the surgery at this time. He tried one session of physical therapy and reported it greatly worsened his pain, numbness and tingling. He reported his left leg and foot weakness is increasing. He states the pain is more intense and constant now. He is taking Norco but this is not covering the pain. He currently walks with a cane due to feeling unstable with his left leg. On physical examination, he demonstrated 50 degrees of flexion, 35 degrees of extension, 40 degrees of right and left rotation, a positive straight leg raising test at 60 degrees, and mild lumbar spasm. She also noted that his L4-5 region was very tender. Physician Assistant Furlong diagnosed radiculopathy and degenerative disc disease of the lumbar sacral spine. She noted that they are trying to get Petitioner on a surgery schedule. She prescribed a Medrol Dosepak and medication.

11. Surveillance was performed on April 9, 2014 and April 27, 2014. On April 9, 2014, Petitioner was seen using his cane, performing prolong standing and bending. On April 27, 2015, Petitioner was viewed close up and seen not using a cane but walking slowly and carrying an item which was possibly groceries.

12. On April 19, 2014, Petitioner went to Saint Anthony Hospital's emergency room where he provided a history of having a headache and vomiting for three days. He was diagnosed with headaches, vomiting, esophagitis, gastroenteritis and miscellaneous digest disorders.

13. On April 23, 2014, Petitioner was evaluated by Dr. Soriano who noted that Petitioner reported his pain is located in the midline at L5-S1 and is present only on an intermittent basis. He reported his pain is worse when he twists or performs prolong sitting, standing or walking. He further reported that he is better when he is in a recliner.

On physical examination, his sagittal balance, which is the way that he stands with the relationship of his head to his pelvis, was normal. He was able to walk

normally. He could support his weight on his heels and toes. He was able to get on and off the exam table without difficulty. He removed his own shoes and socks without difficulty. When he was asked to bend forward, backwards and to the side, all of those directions were limited to less than five degrees because of his subjective low back pain complaints. Petitioner tested positive for light touch to the skin, pushing on top of the head and simulated truncal rotation. His straight leg raising was to 90 degrees while sitting but was only to 45 degrees on the right and 10 degrees on the left in the supine position.

Dr. Soriano noted that on March 3, 2014, Petitioner reported significant discomfort in his left leg. An examination does not appear to have been performed on this date. Petitioner was diagnosed with radiculopathy. On March 10, 2014, Dr. Ogan diagnosed Petitioner with low back pain and radiculopathy. The exam showed no neurological deficits other than left hip flexion at 4/5. His right knee flexion/ extension was 4/5. His dorsiflexion on the left and his foot extension are 4/5. Dr. Ogan diagnosed low back pain with constant radiating pain in the left posterior buttock, thigh and calf. On March 21, 2014, Dr. Rerri noted Petitioner has advance degeneration at L4-5 with over 3 millimeters of retrolisthesis. He found Petitioner's alignment was kyphotic and he recommended a transforaminal interbody fusion to address post-laminectomy instability.

Dr. Soriano noted that after reviewing the records and radiological studies and performing a history and physical examination, it was his opinion that the diagnoses was status post soft tissue injury to buttock, low back and possibly left hip. His diagnosis also included Petitioner expressing subjected pain complaints that had no relationship to any radiological findings or the physical examination and which were exaggerated in nature. He opined that Petitioner's soft tissue findings are causally related to the February 15, 2014 incident but his degenerative changes have no relationship to February 15, 2014 incident.

Dr. Soriano opined that given his diagnosis Petitioner maybe should see have a spine surgeon or occupational medicine doctor and had some physical therapy. He opined that the steroid shots were not indicated. He stated that that a soft tissue injury would require a period of 4-6 weeks off of work at most. He further opined that Petitioner may have benefited from a chiropractic or physical therapy followed up with a home exercise program and over the counter medications. He opined that Petitioner had reached maximum medical improvement as of the April 23, 2014 evaluation and further opined that Petitioner does not need to be off of work and he requires no restrictions.

14. Surveillance was again conducted on April 24, 2014 and April 27, 2014.

On April 24, 2014, Petitioner was seen using a cane, bending, kneeling and lifting. On April 27, 2012, Petitioner was seen close up. He was not using a cane and he was seen walking slowly and carrying item.

15. On April 30, 2014, Petitioner was seen at Saint Anthony Hospital's emergency room. Petitioner reported that he awoke with back pain, dizziness and not feeling well. The doctor noted that Petitioner reported suffering a back injury in February of 2014 He has had pain over the low back and left sacral region with radiations to the buttock and lateral aspects of the entire left leg to the foot. He rated his pain as being 7-8 out of 10. He reported he is experiencing vertigo on and off all day. He reported he has had nausea for the past two days. He said he has been taking approximately three Norco tablets per day. The doctor diagnosed him as experiencing acute low back pain and vertigo. He prescribed medication for dizziness, told him to take an over-the-counter medication for nausea and to follow up with Dr. Rerri in one week.

16. On May 13, 2014, Petitioner saw Physician Assistant Furlong who noted Petitioner is waiting for approval for surgery. In the meantime, he reports having increased pain which is worse mostly in his back but he is having more and more numbness, tingling and weakness in his left leg. She noted that Petitioner has been to the emergency room three times. The last time was two weeks ago after experiencing uncontrollable pain. He has been taking Norco. However, this is making him nauseated and dizzy. He reports he is unable to sleep due to the pain and discomfort. Physician Assistant Furlong stated Petitioner is to remain off work until further notice since he cannot tolerate even walking at this time. While Petitioner does currently ambulate with a cane, he has been experiencing increased pain with any movement of his spine. Norco made him sick so we will try Valium to help him sleep. Petitioner should continue using heat/cold. He should remain off of work and follow up with Dr. Rerri in four weeks.

17. On June 9, 2014, Petitioner followed up with Dr. Rerri. At that time he reported he was still having trouble with his back and left low extremity. He noted that Petitioner still has difficulty walking. He is using a cane and his examination confirms he is obviously disabled by pain although he has no leg weakness. Dr. Rerri once again recommended surgery.

18. Surveillance of the Petitioner on June 14, 2014 showed Petitioner using a cane, bending and gardening. Surveillance on June 25, 2014 showed Petitioner using no cane, bending, kneeling and using a leaf blower. Surveillance on July 2, 2014 showed Petitioner not using a cane, bending a lot and standing a long time. Surveillance on August 3, 2014 showed Petitioner using no cane but walking slowly.

19. On September 17, 2014, Petitioner saw Physician Assistant Furlong who noted that surgery has been recommended by Dr. Rerri and myself. The Petitioner sustained a fall a

few weeks ago and he experienced an increase in his pain. However, his symptoms were the same as before. He stated the pain which radiates from his low back down into his left leg increased after the fall. He reported he still has numbness and tingling in the left leg down to his foot along with weakness in his left leg. He reported that he is unable to walk without assistance from a cane or walker as a result of his pain and left leg weakness. He reported that he has been having multiple episodes of his left leg giving out very recently and that this was not the only fall he sustained. X-rays of his lumbar spine show no fractures or dislocation. There is no anterolisthesis or retrolisthesis except for some very mild retrolisthesis of L4 over L5, which is present in his old x-rays. Physical Assistant Furlong noted that Petitioner has an almost complete disc space collapse at L4-5 and has severe degenerative changes at L5-S1 as well. He has anterior bridging osteophytes at L4, L5 and S1. She noted that it has been recommended that he undergo surgery. He is in the process of getting his own private insurance. If workers' compensation will recommend or cover the surgery, he will let her know. In the meantime, Petitioner will be seen on an as-needed basis and he was instructed to call when he wished to schedule the surgery.

20. On September 18, 2014, Petitioner was seen at Saint Anthony's Memorial Hospital. At that time, he presented with a sudden onset of nausea, sweats and vomiting. His discharge diagnosis was atypical chest pain, probable esophagitis with esophageal spasm, constipation and chronic low back pain. On October 9, 2014, a cardiac stress test was administered at St. Anthony Memorial Hospital.

21. Surveillance of Petitioner was conducted on the following dates. On October 29, 2014, Petitioner was seen bending and using no cane. On November 11, 2014, Petitioner was seen using no cane, resting, walking slowly, bending and carrying a bucket on his left side. On April 7, 2015, Petitioner was seen using cane, driving an all-terrain vehicle side saddle and dragging a large trash can behind him. On April 21, 2015, Petitioner was seen using a cane, filling, emptying and carrying a bucket of water.

22. On February 9, 2015, Dr. Rerri, a Canadian board certified orthopedic surgeon, was deposed. He testified that he specializes in spine surgery. He first saw Petitioner on March 21, 2014 upon a referral from Dr. Rudert. He found Petitioner was in severe pain and was in fact sitting in a wheelchair. He reviewed Petitioner's March 3, 2014 lumbar MRI which showed a kyphortic, abnormal alignment. A normal alignment of the lumbar spine is almost C shaped but Petitioner's was straight. He noticed that the apex of that alignment was at the L4-5 level where Petitioner had undergone a prior surgery. He further noted that there was a lot of wear and tear from the disc at L4-5 and in fact, the 4th vertebrae had slipped backwards on the 5th. Those are all the features of what we call post laminectomy instability. Dr. Rerri testified that Number 4 disc should sit squarely on number 5 disc. When there is instability, the number four disc can slide forward or backwards. In Petitioner's case the sliding was backwards by 3 millimeters, which Dr. Rerri opined is kind of a significant amount.

He diagnosed Petitioner at that time as having post laminectomy instability at the L4-5 level.

Dr. Rerri testified that he felt, that despite interventions by Drs. Ogan and Rudert, that due to the severity of Petitioner's complaints and his clinical state, at the time, Petitioner would be a likely be a candidate for structural correction of the problem. His initial suggestion was to try some physical therapy to see how much he could reduce Petitioner's discomfort and he also felt that he would offer him a fusion between the 4th and 5th disc to address the structural problem. Dr. Rerri stated that the goal of the fusion was to bolt 4th disc to 5th disc so there would be no further movement.

Dr. Rerri opined that the February 2014 work injury aggravated and exacerbated Petitioner's post laminectomy instability. It put Petitioner in an unstable and painful situation that led him to recommend surgery. Following this injury, things changed. Prior to the last surgery, Petitioner was able to work full time and do all the things we expected him to be able to do. However, after the most recent injury he is now in severe pain and he could hardly walk as evident by him being brought to me in a wheelchair and despite a lot of prior interventions. Dr. Rerri testified that the imaging correlated with what he could see on examination and physical findings. He concluded that Petitioner would benefit from a fusion at the L4-5 level to address his post laminectomy instability, which had been aggravated and exacerbated by the recent injury. He opined that Petitioner's left leg complaints resulted from the vertebrae sliding out of position which in turn reduced the space for the nerves. Additionally, he carried with him some scar tissue from his prior surgery. Dr. Rerri testified that this compression of the nerves in addition to repetitive instability explains Petitioner's back and left lower extremity pain. From his experience, although both sides are affected by this kind of pressure and instability, patients tend to complain of more of one particular extremity than the other.

Dr. Rerri was shown that the physical therapist's records which showed three Wadell signs. He was asked to comment on it and he stated he thinks that a person who has had prior surgery with a successful relief and who is experiencing recurrent symptoms and coming in to see him with a wheelchair with signs and symptoms is an inappropriate candidate for Waddell testing. He said Petitioner had physical signs. He had imaging signs. So Waddell does not really apply here. He went on to say it may apply if you have a patient that complaints but no physical signs or who had imaging that was entirely normal but this is not the case here. He said, "I'm just putting it graphically but it's totally inappropriate for the therapist to comment on Wadell signs in this kind of patient with clear structural abnormalities."

Dr. Rerri testified he relies on his Physician Assistant's reports and uses them in making his diagnosis and treatment plan. With that in mind, he was asked to comment on Physician Assistant Furlong's September 17, 2014 entry in which she noted that Petitioner has numbness and tingling in the left leg. He admits to having weakness in the

left leg. He is unable to walk without assistance and he is falling because his left leg is giving out. Based on that entry, he opined that Petitioner's left leg was giving way based on his prior leg pain. Dr. Rerri opined that Petitioner has an instability problem when he moves or turns. He cannot predict when the disc shift is going to happen and there is going to be a pinch along the nerve. "It comes to him like a shark down the legs". It can just cause him to drop to the ground. In general, it can make people feel sick, constipated, exhibit urinary problems along with experiencing trouble walking and needing to rely on walking aids. These are all symptoms of instability which Petitioner had at the L4-5 level.

When he looked at Physician Assistant Furlong's notes he believes they reflect the severity of Petitioner's condition. He agreed that Physician Assistant Furlong indicated that the x-ray findings showed no fracture or dislocation. She noted that there is no anteriolisthesis, which is a forward shift. She also said there was no retrolisthesis, which is a backward shift. Then she stated that there is some very mild retrolisthesis of 4 over 5 which is seen on Petitioner's old x-rays. So, on the one hand, she is saying there is no retrolisthesis but on the other hand she states there is some retrolisthesis of 4 over 5. Dr. Rerri comments that he likes the detail his Physician Assistant goes into on her exam and patient inquiries, but he relies on his own findings for some of the key elements.

On cross-examination, Dr. Rerri said he examined Petitioner twice. He agreed that the radiologist reported significant loss of disc thickness and signal at the 4-5 level with mild defused disc and osteophyte formation, that there is uncomplicated appearing L4 laminectomy with adequate decompression of the canal and the alignment of the spine is normal across the level and throughout the lumbar and visualized thoracic spine. Dr. Rerri testified that significant loss of disc place means that the space for the disc grinds down and the space becomes much less, which could be caused by injury, wear and tear or it could be accelerated by a prior surgery. Given the fact that the MRI took place on March 3rd, shortly after the February 15th accident, he believes that the disc thickness dates back to the prior surgery, that the loss of disc height did not happen between the work injury and when this was taken. He agreed that it would be a chronic finding. He agreed that the osteophyte formation could not have happened between the February 15th accident and the March 3rd MRI. He does not know what the radiologist phrase uncomplicated L4 laminectomy means. What he think it means is that there is a wide central canal. So when the radiologist said there is adequate decompression he is saying there is adequate room for the nerves inside the central canal. He does disagree with Radiologist Lyons' assessment that the alignment of the spine across the L4-5 level was normal. Dr. Rerri testified that the radiologist has not seen the patient and all he is looking at are his images. At most, the radiologist is describing what he sees. He is not a surgeon. So what is uncomplicated or looks normal is different to him than it is for me. If you look at my report, it is two lines because I go in and look for what I'm looking for. He had a whole page of it. Dr. Rerri agreed that the radiologist does not mention retrolisthesis because that is not very important to him. Dr. Rerri said he is not looking at

the radiologist's report and he hardly ever looks at a radiologist's report. He disagrees with Radiologist Dr. Lyons' finding that the alignment of the spine at L4-5 is normal.

He did not see Dr. Soreano's evaluation. If Dr. Soreano did not feel there was any instability to L4-5, he would disagree with him. So in response to the question of if you disagree with Dr. Soreano, a neurosurgeon, your Physician Assistant, Radiologist Lyons and Dr. Rudert, is this just based on your own personal review of the MRI, Dr. Rerri said yes. Most of his practice is in spine surgery. In this office, in his practice, as a supervisor, it is his view that is presented as the final view. So, whether there is a discrepancy between Physician Assistant Furlong and himself, it is that his view is the correct version. The same applies for Dr. Rudent who is an independent practitioners and not a spine specialist. Dr. Rerri testified that medicine is not an exact science. It is an art and that is why some of it is left to people who are most familiar with it. He agreed that it is possible for two reasonably competent doctors to look at the same image and come up with different findings. He followed this up with the understanding that the person looking at the patient usually makes the final determination because he is most familiar with the circumstances. Dr. Rerri said he thinks that if a patient is in pain it is best established by repetitive examination, observation, information from other treating doctors and health providers. He does not think it is something that you pick up at one visit or one evaluation.

He did agree that when Petitioner attended the deposition, he did not come to the deposition in a wheelchair. Rather, he was using a walking aid. When he was asked if he was presented with evidence of Petitioner ambulating without assistance in a free and fluid manner would it surprise him and Dr. Rerri said yes it would surprise him. He prefers to look at what the physical therapist considered as the remaining impairment, that there's decreased strength, an unsafe and abnormal gait and difficulties with ADLs. He said this is the same physical therapist that noted this very specific impairments and he finds that the same are not keeping with physical therapist's finding of positive Wadell signs.

23. Dr. Soriano, a board certified neurosurgeon, was deposed on September 9, 2014. He testified that his practice focuses entirely on spinal surgery and peripheral nerve surgery. He evaluated Petitioner on April 23, 2014. Petitioner told him at the time of the exam that his pain was intermittent and was worse when he twisted, sat or stood for a long period of time. His best position was in the recliner. At the time he saw Petitioner, Petitioner told him that he did not believe he could return to work as an over-the-road truck driver. He reported that during the day he sits at home and watches television. He said he has not driven a car since the injury. He did not have a second job. His leisure activities include riding motorcycles, hunting and fishing. He does not smoke, drink or exercise.

Dr. Soriano testified he reviewed the radiological films and medical records for the Petitioner. The radiological films showed disc spaces at L4-5 and L5-S1 were significantly collapsed, particularly at L4-5. There was evidence of his prior surgery for the disc on the left at L4-5. The L2-3 disc space was also collapsed and at that level there was facet fluid at L2-3 and L3-4. He had a bulging disc at L5-S1. There was also facet fluid there and a narrowing of the left L5 foramen. His plain x-rays from February 18, 2014 showed, again, severe collapse and spurring to the right at L4-5. He had lost some of his normal lumbar curve. The disc space at L5-S1 was collapsed. He had an anterior traction spur of L4 and L5, which is basically a calcium deposit for bones and discs that are deteriorating and collapsing. He performed a physical examination and found Petitoner's sagittal balance, which is the way that he stands with the relationship of his head to his pelvis, was normal. He was able to walk normally. He could support his weight on his heels and toes. He was able to get on and off the exam table without difficulty. He removed his own shoes and socks without difficulty. When he was asked to bend forward, backwards and to the side, all of those directions were limited to less than five degrees because of his subjective complaints of low back pain. He was using a cane. When he asked Petitioner why he used a cane, Petitioner said it was for balance. He also said the cane was used because he felt like he was going to fall at times. However, he did not use it during the exam. His strength in his legs, his sensory exam and his reflexes were all normal. He performed a series of Waddell tests. Petitioner tested positive for light touch to the skin, pushing on top of the head and simulated truncal rotation. His straight leg raising was to 90 degrees while sitting but was 45 degrees on the right and 10 degrees on the left in the supine position. All and all, Petitioner demonstrated four positive Waddell tests. In the March 25, 2014 records from Biomax Rehabilitation Services, the therapist found Petitioner tested positive for some Waddell signs and stated that there was an indication that there may be symptom magnification present. It was basically the same thing he found. After the record review and physical examination, he diagnosed Petitioner with soft tissue injury to the buttock, low back and possibly left hip as a result of the slip and fall. He also diagnosed him with a post-surgical left L4-5 disc removal and a stable spine. Dr. Soriano testified that his diagnosis also included Petitioner's subjected complaints of pain, which he found had no relationship to any x-rays, physical examination and in his opinion were exaggerated in nature. His opinion is based on the four positive Waddell signs, his review of the radiological studies and the physical exam findings, Petitioner's history along with his record review. He opined that Petitioner's soft tissue injuries were related but the degenerative changes had no relationship to the incident. He further opined that Petitioner's pre-existing degenerative condition to his spine was not aggravated or exacerbated by his work accident. He testified that Petitioner required an MRI. Maybe he should have seen a spine surgeon or occupational medicine doctor and had some physical therapy. He does not believe the steroid shots were indicated. He believes that if Petitioner had any pain from the soft tissue injury a period of 4-6 weeks off of work would have been reasonable. Dr. Soriano testified that Petitioner may have benefited from a chiropractor or therapist followed up with a home exercise program and over- the-counter medications. He opined that

Petitioner reached maximum medical improvement as of his April 23, 2014 evaluation. He further opined that Petitioner does not need to be off of work and he requires no restrictions.

On cross-examination, Dr. Soriano testified that he did not give Petitioner a pain disability questionnaire to complete as part of his evaluation of an impairment of the spine. He said that given the fact that this man had no positive physical examination findings, no objective injuries and four positive Waddell signs, he would have discounted Petitioner's pain ratings anyway as part of determining his impairment. Dr. Soriano said he probably spent 10 minutes or less physically examining Petitioner. In addition to the 10 minute exam, he spent 20-30 minutes talking to the Petitioner. Dr. Soriano testified that if there are three or more positive Waddell tests, this is a strong indicator of symptom magnification. He testified that Dr. Rerri said he was going to address post-laminectomy instability. The only problem with that is there is no instability at L4-5. Dr. Rerri called it radiculopathy but if you read Petitioner's physical exam findings there is no radiculopathy. He agreed that Dr. Ogan found weakness in numerous muscle groups and he has diagnosed radiculopathy. So he does not disagree with the use of the term in that situation. In reviewing the films, he saw nothing that shows a need for surgery or that is related to the work accident.

On redirect examination, Dr. Soriano opined that surgery would be the worst thing you could do for Petitioner who has four plus Waddell signs and has no instability. Dr. Soriano testified that on everyone's exam, except for Dr. Ogan's exam, he had no radiculopathy and even Dr. Ogan's states "radiculopathy involves so many different nerve roots that it would have nothing to do with L4-5." Dr. Soriano said that surgery would be a complete disaster for Petitioner and he truly believes that surgery does not really have any role in the treatment of Petitioner, particularly when his pain is midline and he does not have radiation down his legs; he does not have numbness, tingling or weakness associated with it. It is really inconceivable how someone would recommend a fusion for someone who had a midline low back pain. It just does not follow the standard of care. He testified that Dr. Ogan never ran a single Waddell test. So he thinks it is important that the physical therapist supports his opinion that there were positive Waddell signs that indicated symptom exaggeration.

The Commission finds Petitioner's credibility is lacking and having found so believes that Petitioner's lack of credibility provides a basis for which to modify the causation holding in this case.

More specifically, the Commission notes that Petitioner initially treated with Dr. Rudert, D.O. Post accident, Petitioner makes two complaints. One, being low back and left hip pain and two, being radiating pain accompanied by numbness and tingling down the left leg. Dr. Rudert examined Petitioner and reviewed his x-rays. He erroneously found Petitioner had a pre-existing lumbar condition which looked to be a prior fusion

and which is subsequently noted by other treaters to be a laminectomy. He also notes there is not a lot of evidence of radicular pain. As such, he only addresses Petitioner's low back and hip condition in his diagnosis and he made no diagnosis of radiculopathy. As a precautionary measure, he prescribed crutches and/or a cane for the right hip. Note, it was not for the left leg and he does not prescribe a wheelchair. He also orders a lumbar MRI. The MRI is read to show degenerative disc disease at two levels along with "mild" left-sided neural foraminal compromise at the L5-S1 level. In the follow up visit, Petitioner reported left discomfort which Dr. Ruders identifies as a "new" problem which he diagnosis as radiculopathy. He then refers Petitioner to Dr. Ogan

Dr. Ogan diagnosis lumbar nerve irritation at two levels on the left side, displacement of the lumbar but with no "myelopathy" and radiculitis. Rather than ordering a confirmation EMG/NCV he prescribes an epidural injection. Three days after the injection, Petitioner states "it did not work" and his pain is "intense and intolerable". Since the doctor is not in, Petitioner is instructed to go to the emergency room. When Petitioner arrives at the emergency room on the same day he now reports his lower extremity numbness and tingling stop at the thigh. He does not report that it is "intense and intolerable" or that it is going down the left leg but only to his thigh and that it is "intermittent" in nature.

Next Petitioner sees Dr. Rerri in one of only two visits in total with the doctor. At that time, he arrives in a "wheelchair". Petitioner reports he is in "severe" pain. Dr. Rerri's first impression is a wheelchair bound individual presenting himself in "severe" pain who can "hardly walk". Dr. Rerri reads Petitioner's MRI as showing significant degenerative disc disease with a significant sliding backwards of one of his discs. The Commission notes that Dr. Rerri stands alone in this assessment. His own Physician Assistant subsequently only finds "very mild" retrolisthesis of L4 over L5 from his old x-rays and no other doctor opines that there is retrolisthesis at all. On the first visit, Dr. Rerri expresses a positive causation and finds that Petitioner's current condition is related to his recent work accident. He notes that due to the severe pain Petitioner is incapacitated and this is in spite of his treatment. The Commission notes that thus far Petitioner's treatment has been limited to only one epidural injection and some pain medication. Dr. Rerri further opines after only the first visit that Petitioner is a surgical candidate for a fusion. In an attempt to dissipate some of the pain he then sends him to physical therapy.

Of all the medical records, the Commission finds that the physical therapy record provides the most thorough examination and is definitely enlightening as to Petitioner's and his wife's mind set and behavior. It begins with the therapist recording a history of Petitioner taking pain pills like candy. Petitioner reports left leg radicular pain not just down to his thigh but down the entire leg. Petitioner is using a cane in the wrong hand to walk. His wife reports that Petitioner has already been deemed a surgical candidate, that therapy was "stupid" and would make things worse and tells the therapist "good luck" in

trying to get Petitioner's range of motion. Petitioner, himself, appears to put on a show by exhibiting facial grimacing, reporting pain prior to stretching the hamstring beginning, has sensation in his lower extremity despite reporting numbness and tingling, reports a generalized decrease in strength, shows he is restricted and reports pain with all motions. More specifically, when he was aware of the testing he expressed pain with straight leg raising at 50 degrees but he was able to perform the same test without any pain complaints when he was distracted. When he is put through Waddell testing, he scores positive in 3 of 5 tests and more specifically he scores positive in simulation, trunk rotation and distraction. The therapist concludes her examination by stating that there may be symptom magnification, the Petitioner had poor tolerance with the evaluation and stated he would be unable to tolerate therapy and there are no physical therapy goals being established at this time. The following day Petitioner telephones the nurse at Dr. Rerri's office and tells him that the pain was too bad and he wants to proceed with the surgery. This is followed a couple of days later by Petitioner telling Physician Assistant Furlong that physical therapy "greatly worsened his pain" and now his left leg and foot are weaker and he is in more intense and constant pain now.

When Petitioner is evaluated by Dr. Soriano approximately three weeks later, Petitioner's exam can be summarized as follows. When he is aware of the doctor watching him, he is in pain and limited in his mobility. When he is not aware of the doctor watching him he is able to stand, walk, support his weight, move without difficult and bend down to remove his shoes and socks without a problem. At most, he reports "intermittent" midline back pain with twisting, sitting and standing too long and he does not speak of radicular left leg pain. He also told the doctor that he cannot return to work. Dr. Soriano finds at most Petitioner demonstrates a soft tissue injury to his low back, buttock and possibly left hip. He further finds that Petitioner is exaggerating his condition. His subjective pain complaints have no relationship to the objective radiological findings or his physical examination and he tested positive for four of the Waddell signs.

The video surveillance that takes place once before Dr. Soriano's evaluation and at least over twelve sessions in the next year provides a mix bag. The surveillance shows Petitioner using his cane sometimes but not at other times. This is contrary to Petitioner's representation to several of the medical providers that he must use an assistive device and his comment to Physician Assistant Furlong that he needs a cane or walker. Again, the Commission wonders where did the walker come from? At times during the surveillance, Petitioner is walking slowly, sitting, resting and being a passenger in a car while other times he is standing for prolong periods. Again, this is contrary to Petitioner's own testimony that he can only stands for 5-10 minutes before it gets painful. He is also seen bending, kneeling, lifting/carrying, driving ATV sidesaddle, filling/emptying, carrying water bucket and possibly groceries, gardening and fixing vehicles. Petitioner reports to various medical providers at times that his pain is constant while other times it is intermittent. So, the Commission infers that he may explain some of his activities he

performance while under surveillance as having been conducted on his good days as opposed to his bad days.

Following Dr. Soriano's evaluation, Petitioner reports increased pain mostly in his back but with also radiation down his entire left leg and foot resulting in more numbness, tingling and weakness. On May 13, 2014, he reports to Physician Assistant Furlong that he cannot tolerate even walking at this time and she notes he is using a cane.

The second time Dr. Rerri sees Petitioner, Dr. Rerri provides a short and sweet medical entry. He reports he re-examines Petitioner who is still having trouble with his back and left leg. He is having difficulty walking and is using a cane. He concludes that the exam confirms the "man is obviously disabled by pain".

On September 17, 2014, Petitioner reports to Physician Assistant Furlong that he sustained a fall a few weeks ago with an increase in pain but he is still the same symptoms he had before. Petitioner reports numbness, tingling, weakness in the left leg, that he must use a cane or walker, which is contrary to the subsequent surveillance where a cane is not used, and he has had multiple episodes of his left leg giving out recently and this is not the only fall he has sustained. The Commission finds that the report of multiple episodes of his left leg giving out is interesting since there is no prior record of the left leg giving out or other falls in the medical record. As stated earlier, Physician Assistant Furlong reviews Petitioner's radiographic records and finds some "very mild" retrolisthesis of L4 over L5 in his old x-rays.

In his deposition, Dr. Rerri, the treater who only saw Petitioner twice, states during cross-examination that if a patient is in pain it is best established by repetitive examination, observation, information from other treating doctors and health providers. When he was asked about the other health providers in this case that did not find the retrolisthesis and found positive Waddell signs such as Radiologist Lyons, Drs. Soreano and Rudert, the physical therapist and his own physician assistant he finds them to be wrong or less skilled them himself. He claims that a he is most familiar with Petitioner, again, having only seen him twice as opposed to Dr. Sorenano's one visit. He placed a lot of credence in his personal observation of wheelchair bound Petitioner who could hardly walk and believes this gave him a leg up on the other medical providers. When he was asked if he was presented with evidence of Petitioner ambulating without assistance in a free and fluid manner, he said he would be "surprised". The Commission notes that the surveillance footage was not shared with the doctor. As noted before, the surveillance footage is not a smoking gun but it clearly demonstrates Petitioner had greater mobility than he was reporting to the doctor. Not once is he seen in a wheelchair and at times he is seen walking without a cane, bending, kneeling, standing for prolonged periods of time, carrying items, etc. This all has to be factored into Dr. Soriano's finding in which he concludes that Petitioner has long since reached maximum medical improvement and that

surgery would be a complete disaster for the Petitioner at this time since it does not really have a role in his treatment and to recommend a fusion is inconceivable and does not follow the standard of care that is warranted in this case.

Given all of the above, the Commission notes that Petitioner established a work accident took place on February 15, 2014 and that the same was stipulated to by the parties. The Commission finds that what Petitioner did not establish under the manifest weight of the evidence is that the recommended surgery is causally related to and needed as a result of the February 15, 2014 work accident. There is no doubt that Petitioner was injured as a result of the injury and that said injury was superimposed on Petitioner's extensive pre-existing degenerative condition. The Commission finds that what Petitioner did not prove is that his injuries have resulted in the need for surgery. The evidence supports the fact that Petitioner, the wheelchair bound patient, demonstrated time and again signs of symptom magnification and greater mobility than he cared to share with his medical providers. Dr. Rerri accepts Petitioner's subjective pain complaints while others medical personnel did not. Additionally, more conservative methods of diagnosis and/or treatment such as additional epidural injections, EMG/NCV were not utilized prior to there being a determination that surgery was warranted. Based on all of the above, the Commission reverses the Arbitrator's findings of credibility and causation.

Having reviewed the April 19, 2014 and April 30, 2014 medical records, the Commission finds that the same are not causally related to the claimed low back/ left leg condition. Additionally, the Commission finds that the evidence above shows that Petitioner reached maximum medical improvement as of the April 23, 2013 evaluation with Dr. Soriano. As such, the Commission vacates any award of medical bills from April 24, 2014 through June 2, 2014, the last date a medical bill was submitted. Based on the causation discussion above, the Commission reverses the Arbitrator's finding regarding ordering prospective medical care.

Lastly, based on the record above, the Commission modifies and finds Petitioner was temporarily totally disabled from February 15, 2014 through April 23, 2014, the date Dr. Soriano opined Petitioner had reached maximum medical improvement.

IT IS THEREFORE ORDERED by the Commission that Petitioner failed to prove a causal relationship exists between the February 15, 2014 work accident and Petitioner's present condition of ill-being.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $435.00 per week for a period of 9-4/7 weeks, that being the period of temporarily totally incapacity for work under Section 8(b), and that as provided in Section 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.

17IWCC0057

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner is entitled to any medical bills spanning from February 15, 2014 to April 23, 2014 and any medical bills after April 24, 2014 are hereby vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that the April 19, 2014 and April 30, 2014 medical services are not related to the February 15, 2014 accident and the award for the same is hereby vacated.

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

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

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit in the amount of $8,339.66 for payment of current medical bills and $4,789.73 for payment of temporary total disability benefits paid to or on behalf of Petitioner on account of said accidental injury.

No bond is due and owing for the removal of this cause to the Circuit Court by Respondent.

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

DATED: JAN 3 1 2017

Mario Basurto

Stephen Mathis

MB/jm

O: 12/8/16

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17IWCC0057

Dissenting Opinion

I respectfully dissent from the majority decision and would affirm the Arbitrator's well reasoned decision in its entirety. Although Petitioner's presentation to his treators could be characterized as being odd at times, the Arbitrator had the opportunity to observe Petitioner's demeanor and hear Petitioner's testimony live. After hearing petitioner's testimony, the arbitrator found Petitioner to be credible notwithstanding his somewhat odd presentation to his treators and the purported inconsistencies in his medical records. The basis of the majority's modification of the Arbitrator's decision is Petitioner's credibility or lack thereof. I would defer to the credibility finding of the trier of fact who had the opportunity to hear the Petitioner's testimony in person. Accordingly, I would affirm the Arbitrator's well-reasoned decision in its entirety.

David L. Gore

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Brian Little,

Petitioner,

vs.

NO: 16 WC 03648

State of Illinois/Vienna Correctional Center,

17IWCC0058

Respondent,

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 19, 2016 is hereby affirmed and adopted.

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $5,000.00. 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 31 2017

MB/mas
o:1/5/17
43

Mario Basurto

David L. Gore

Stephen Mathis

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

LITTLE, BRIAN
Employee/Petitioner

Case# **16WC003648**

17IWCC0058

STATE OF IL/VIENNA CORR CENTER
Employer/Respondent

On 7/19/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.43% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

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2101 S VETERANS PARKWAY
PO BOX 19255
SPRINGFIELD, IL 62794-9255

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

JUL 19 2016

MICHAEL A. BASCIA, Acting Secretary
Illinois Workers' Compensation Commission

17IWCC0058

STATE OF ILLINOIS)
)SS.
COUNTY OF MADISON)

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

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

BRIAN LITTLE
Employee/Petitioner

v.

STATE OF ILLINOIS / VIENNA CORR. CENTER
Employer/Respondent

Case # **16** WC **03648**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Paul Cellini**, Arbitrator of the Commission, in the city of **Collinsville**, on **April 20, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **December 23, 2015**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$64,560.00**; the average weekly wage was **$1,241.53**.

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

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

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

Respondent is entitled to a credit for **any medical benefits paid through its group carrier** under Section 8(j) of the Act.

ORDER

The Petitioner sustained accidental injuries arising out of and in the course of his employment with the Respondent on December 23, 2015.

The Petitioner's left ankle/foot condition is causally related to the December 23, 2015 accident.

Respondent shall pay Petitioner temporary total disability benefits of **$827.69** per week for **6 weeks**, commencing **December 24, 2015 through January 28, 2016** and from **April 15, 2016 through April 20, 2016**, the date of hearing, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from December 23, 2015 through April 20, 2016, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall pay the causally related reasonable and necessary medical services, pursuant to the medical fee schedule, contained in Petitioner's Exhibits 1 and 7B, as provided in Sections 8(a) and 8.2 of the Act.

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

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

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

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

Signature of Arbitrator

July 11, 2016
Date

ICArbDec19(b)

JUL 19 2016

STATEMENT OF FACTS

Petitioner worked as a correctional officer at Respondent's Vienna Correctional Center. On 12/23/15 he was assigned as a gymnasium officer and sustained an injury while descending stairs at the gym building. He indicated he was in a hurry at the time, and testified as follows:

> "... I incurred a fall while in route to intercept the Building 19 recreation line that's coming down from Building 19 to use the gymnasium, which would have been my recreation line, from crossing the Zone 2 weight pit line which was at that time accessing the large weight pit which is located in Zone 3 which is located right outside of the Building 19 exterior and those two lines will in fact cross somewhere around the Zone 1 area if an officer is not there to actually direct the traffic. . . I was descending the steps I was trying to get there before these two large lines crossed. . . I was in a hurry because these are two large lines and I was pressed for time." (Tr. 49-50).

While Major Cox, one of the Petitioner's shift supervisors, testified that only one line is run at a time to prevent two lines from crossing each other, the Petitioner testified that this extra line movement was a new arrangement instituted by Respondent on Tuesdays and Wednesdays in the two months prior to the alleged accident. The Arbitrator notes that 12/23/15 was a Wednesday. The Petitioner noted that there had been talk amongst the officers as to why the Respondent was moving two large inmate lines in a way where they could cross each other. Major Cox was not called to refute this testimony of the Petitioner.

Petitioner testified that as he was in a hurry to go down the stairs, his left foot slipped and missed a step and his right foot slipped from underneath him due to rain and moisture on the steps, causing him to fall forward to the ground." He testified:

> "Due to just all of the rain and the moisture on the steps. When I was descending the steps my left foot slid out from underneath me. It was still drizzling at that time, it had been raining all night and raining on and off and drizzling that day and when my left foot slid out from underneath me it slid

> inward which turned my ankle inward and as my momentum was carrying me down the steps my ankle turned inward and then continued down the steps turning my ankle up and inward and when I finally got to the landing of the steps I actually landed with my foot turned upward which caused me to collapse while trying to catch my body weight the best I could I was able to pull my right knee up to some degree and my palms up to about chest height to catch myself, but the fall was very sudden, I literally just collapsed onto the ground [sic]. I was hustling, I was moving fast and the fall was sudden, I didn't have time to react."

Petitioner testified that he had no prior problems or injuries to his left ankle/foot.

Petitioner's incident report, completed on 12/23/15, states:

> "At Approx 750 AM this c/o was walking down the gym steps that leads to the front entrance of the gym. At this time it was raining and two Recreation lines were coming and going from Bld. 19 and this c/o was trying to hurry to get to get to a staging area to keep the two Rec. lines from crossing. At this time this c/o was walking down the gym steps and slipped and missed the second to last step and landed face first on the concrete ground. This c/o's left ankle Rolled inward providing no support and then the impact was absorbed on this c/o's right knee cap and to some degree face and hands and was (illegible) laid out face first on the ground before this c/o had known what had exactly happened. (Rx4).

A second form titled "Employee Injury Report", which appears to have been signed by a "Stanford RN" on 12/23/15, states: "I missed a step and fell down the steps in front of the gym." (Rx3). The witness form indicates there were no witnesses. (Rx2). The Incident Report completed by Lieutenant Parrish, who the Petitioner initially reported his injury to, on 12/23/15, stated:

> "On the above date and approx. time, this Zone Lieutenant was approached by c/o Little who stated he had missed a step on the stairs in the gym and had fallen. This Lt. asked what injuries occurred? C/o Little stated he fell on his face, Both hands and his knee. This Lt. asked if c/o Little needed to go to HCU? C/o Little refused, stating he was just a 'little sore', he would try and walk it off: this Lt. said ok. Approx 5 min later c/o Little reapproached this Lt. and decided that his knee hurt enough to go to HCU. This Lt. notified the shift commander and health care unit. C/o Little was given a ride to HCU." (Rx4).

A report from the Health Care Unit (Rx5) stated that the Petitioner fell down the steps and rolled his ankle, with pain in the ankle as well as the right knee. There was swelling and bruising noted in the left ankle, abrasions on the bilateral hand/palms, and no obvious injury to the right knee. He was advised to see his personal physician. (Rx5).

The Petitioner testified that he called his family physician and was informed they were closed for the Christmas holiday, so he instead went to Logan Primary Urgent Care Center/Occupational Medicine Clinic, where it appears he was evaluated by a nurse practitioner, Dena Kommer. (Rx6). .

At the facility, the Petitioner reported right knee and left ankle pain, indicating the main problem was constant, moderate right knee pain that was worse with use. The right knee exam was essentially normal, while the left ankle exam noted bruising and swelling with reduced strength and range of motion. He was released to restricted duty and prescribed bilateral axillary crutches and a walking boot for his left foot. Petitioner testified that the prescribed gray pack boot provided significant comfort to his left ankle. A separate report of Dena

Kommer from the same date noted complaints of constant throbbing left ankle pain, and that left ankle x-rays were negative for fracture. Right knee x-rays reflected minor arthritis with joint effusion but no fracture. The progress report stated: "Walking down some concrete steps and miss a step then rolled left ankle route to escort building 19 recreation line." (Px3)

Petitioner returned to Dr. Burchill at WorkCare on 12/28/15, reporting significant ongoing left ankle pain, but no right knee pain. He was diagnosed with a 2nd degree left ankle sprain, took him off work, continued the walking boot and restricted his activities. (Px3).

Petitioner visited his family doctor's office (SIMCA) on 1/13/16 and saw physician assistant Theresa Rogers, who took the following history of the accident: "Here today with complaints of left ankle injury. Pt states that on Dec 23 at about 7:50 am fell down gymnasium concrete steps. He believes that he caught his left heal [sic] on step and missed the next step falling forward down 3 steps. He then landed with his hands on side of head and left ankle was rotated inward and flexed forward so that left lateral ankle was laying flat on the ground. He denies having had dizziness or unbalance prior to fall. He states that he has been up and down these steps many times without issue. He states that it was raining that day and stairs were wet. wet. [sic] . . ." (Px6).

Rogers noted that Petitioner had been told he had a bone chip with possible Achilles tendon tear at WorkCare. The Petitioner noted ongoing constant left ankle pain with weakness and feeling of instability. Noting x-rays showed mild arthritis but no fracture, and due to complaints of severe pain out of proportion to the injury, a CT Scan was prescribed to check for fracture and possible ligament tear. Rogers prescribed Mobic and Norco and instructed Petitioner to be non-weight bearing on his ankle. (Px6).

Petitioner next sought treatment with Dr. Bradley at the Orthopedic Sports Medicine & Spine Care Institute on 1/21/16. (Px7) Dr. Bradley noted the following history of injury: ". . . he is unsure if he missed a step or if his foot slid off a step but at any rate, he suffered a hyper-supination type injury while falling", and also hit his knee. Dr. Bradley noted that despite improvement in pain and swelling, Petitioner continued to note significant feelings of left ankle instability. Examination indicated significant increase in supination on the left versus the right, and based on the mechanism of injury, indicated this was due to the 12/23/15 sprain. He was given restrictions and advised to continue to use the boot. (Px7). An MRI also was prescribed, and the 1/21/16 films indicated some reactive bone marrow edema in the distal fibula and a probable moderate tear of the anterior talofibular ligament. (Px8).

At his 1/28/16 follow-up, Dr. Bradley's review of the MRI films indicated "fairly high-grade tears" to both the anterior talofibular and calcaneofibular ligaments, noting they might be full-thickness tears. Given these findings and Petitioner's persistent feelings of instability, Dr. Bradley recommended ligament reconstruction surgery, noting that while it was only 5 weeks post-injury, the instability has led to continuing reinjuries, and thus a greater risk for further damage and intra-articular pathology. Pending surgery, Dr. Bradley prescribed orthotics that would also be used post-surgery. He limited the Petitioner to sedentary duty. (Px7).

On 4/15/16, just five days before the arbitration hearing, Dr. Bradley performed surgery consisting of modified left ankle Brostrom procedure utilizing allograft. (Px9). The Petitioner testified that he worked light duty from 1/29/16 through 4/14/16.

On 12/24/15, the day after the accident and Petitioner's regular day off, he agreed that he went to get Christmas pictures taken with his family at a mall. Major Cox, consistent with his Incident Report (Rx4), testified that he witnessed Petitioner at the mall on 12/24/15 at the Santa House, and he observed Petitioner bending over to pick up his child from a stroller to get pictures taken with Santa Claus. He indicated that he did not see Petitioner

wearing a walking boot or using any crutches. He testified that he did not complete his incident report until 1/4/16 because he had been off work from 12/23/15 through 1/3/16, and upon his return he was informed that Petitioner had been placed on restrictions and instructed to work with crutches and a walking boot for ambulation with standing/walking to toleration. It is unclear if or how any light duty was or was not offered to Petitioner based on those restrictions and his observations.

Petitioner testified that he was wearing his gray walking boot on the day in question, but it was hidden under his tactical BDU pants which have wide legs and go over the boot with no problem. Petitioner's sister, who was present at the hearing due to driving the Petitioner there after his recent surgery, testified that she was at the mall with Petitioner and his wife on 12/24 and that the Petitioner was, in fact, wearing the walking boot at that time.

CONCLUSIONS OF LAW

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

Petitioner's injuries clearly occurred "in the course of" his duties. He was performing his work duties at the time of moving to direct the inmate traffic to the gymnasium area of the prison when he was injured.

The issue in this case is whether the injury arose out of the employment. An injury arises out of one's employment if its origin is in a risk connected with or incidental to the employment so that there is a causal relationship between the employment and the accidental injury. In order to meet the burden of proof, a claimant must prove that the risk of injury is peculiar to the work or in the case of a neutral risk encountered during the course of employment, that he or she is exposed to the risk of injury to a greater degree than the general public. This increased risk may be qualitative, such as some aspect of employment that contributes to risk, or quantitative, such as the number of times they are required to encounter the risk. *Springfield Urban League v. Illinois Workers' Comp. Comm'n*, 2013 IL App (4th) 120219WC, 990 N.E.2d 284, 290 (2013). A claim for injuries sustained as a result of navigating stairs is not barred where a claimant can prove an increased risk of injury by this neutral risk. *Village of Villa Park v. Illinois Workers' Comp. Comm'n*, 3 N.E.3d 885, 378 Ill.Dec. 320. (2013).

The Petitioner was subjected to an increased risk in this case based on his credible testimony that he was hurrying to position himself in his duty as an officer to direct the inmate line traffic. It makes sense to the Arbitrator that there is a strong interest for the Respondent to avoid any undesired intersection of different groups of prisoners, and the potential danger if a conflict were to occur. Additionally, the evidence supports Petitioner's testimony that it was rainy and wet. Petitioner's contemporaneous incident report (Rx4) indicated that it was raining when he slipped, and his family physician's notes (Px6) also stated that the ground was wet at the time of the injury. The Arbitrator does note that there are records, including the incident report, which specifically state that the Petitioner missed a step, as opposed to slipping the way he described in his testimony. However, the Arbitrator also believes that moisture on the steps could have caused this occurrence, or could have contributed to the manner in which the Petitioner used the stairs that day. This was not specified in the records in evidence, but at the same time, there does not appear to be any other reason for the Petitioner to mention the moisture on the stairs contemporaneous to the accident if, in his mind, it had no impact on the incident.

The Arbitrator therefore finds that Petitioner sustained accidental injuries that arose out of and in the course of his employment with Respondent on 12/23/15.

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

Based on the determination that the Petitioner sustained a compensable accident under the Act, the Arbitrator finds that the Petitioner's left ankle injury is causally related to the 12/23/15 accident.

As noted, the Petitioner credibly testified that he injured his left ankle and right knee, and fell onto his palms, on 12/23/15. He testified that he rolled the ankle, which is also consistent with the medical records in evidence. The right knee injury resolved pretty much as of the 12/28/14 report of Dr. Burchill, which noted 0/10 pain in the right knee.

The initial Incident Report the Petitioner completed on the date of accident reflected that he rolled his left ankle. The initial reports of both the company clinic (Rx5) and WorkCare (Px3) reflect a left ankle injury, and the initial report of Dr. Bradley is also consistent in this regard. Dr. Bradley's report indicated he believed that, based on the mechanism of injury, the left ankle ligament injuries, and resulting instability, were causally related to the accident. There were no medical opinions in evidence which dispute the causal relationship of the Petitioner's left ankle. The discrepancy between the testimony of Petitioner and Major Cox does not, in the view of the Arbitrator, impact the determination of causation. It's clear that on 12/23/15 the Petitioner injured his left ankle – whether he was or wasn't wearing the boot at that time does not impact this finding.

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 various medical expenses in Px1. Additionally, as stipulated in the record, because the Petitioner underwent surgery just days prior to the arbitration hearing, the medical expenses related to the left ankle surgery were not available, and were submitted subsequent to hearing. As agreed by the parties upon the submission of these records, they have been admitted as Px7B. The bills contained in Px1 and Px7B are awarded to the Petitioner pursuant to Section 8(a) and the Fee Schedule (Section 8.2).

The Arbitrator notes that one set of bills in Px7B entails treatment at Herrin Hospital on 3/2/16. As the Arbitrator does not have a medical progress note or other medical document which reflects what treatment was rendered to the Petitioner that day. If this was, as it appears it may be, pre-surgical testing for the left ankle surgery, then the bill is awarded. If, on the other hand, this visit was for a purpose unrelated to the left ankle or left ankle surgery, then that bill is denied.

The Arbitrator also notes that it appears from the surgical bill that some of it may have been paid. If this bill, or any other awarded bill, was paid through a qualifying group health plan coverage to which Section 8(j) of the Act is applicable, the Respondent is entitled to credit for same, so long as the Respondent holds the Petitioner harmless with regard to same.

WITH RESPECT TO ISSUE (K), IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE, THE ARBITRATOR FINDS AS FOLLOWS:

It turned out that the Petitioner's surgical procedure was not prospective at hearing because he underwent the surgery five days prior. As noted above, the left ankle surgery is awarded, and prospectively the Petitioner is entitled to reasonable and necessary post-surgical care as contemplated by Section 8(a) of the Act.

WITH RESPECT TO ISSUE (L), WHAT AMOUNT OF COMPENSATION IS DUE FOR TEMPORARY TOTAL DISABILITY, TEMPORARY PARTIAL DISABILITY AND/OR MAINTENANCE, THE ARBITRATOR FINDS AS FOLLOWS:

The Petitioner was injured on 12/23/15. He was released to light duty at that time, however was scheduled off work on 12/24 and 12/25/15. Inferentially, he provided the light duty restrictions to the Respondent on 12/26/15. If there had been any impact on the acceptance of these restrictions from Major Cox allegedly seeing the Petitioner on 12/24/15 without his boot and crutches, it is unclear how that impact may have occurred on 12/26/15, as Major Cox indicated he had been away from work until 1/4/16. Thus, the Arbitrator would further infer that if no light duty was available with Respondent on 12/26/15 through 1/28/16, it also would not have been available on 12/24 or 12/25/15, regardless of whether Petitioner had those days off or not. It's clear he was unable to return to work upon the provision of these restrictions on 12/23/15, and he therefore was temporarily totally disabled from his employment from 12/24/15 through 1/29/16, as he returned to light duty work thereafter. The Petitioner testified that he returned to light duty work from 1/29/16 until 4/15/16.

He then underwent surgery on 4/15/16, and there is a very strong likelihood that he was held off work from that date through the 4/20/16 date of hearing, the Arbitrator also awards the Petitioner TTD from 4/15/16 through 4/20/16. His entitlement thereafter is based upon Section 8(b) of the Act and any applicable case law, with the Arbitrator noting that the surgery has been determined to be causally related to the accident, and thus all reasonable and necessary causally related care and treatment thereafter.

The Arbitrator finds that the Petitioner is entitled to TTD from 12/24/15 through 1/28/16, and from 4/15/16 through the 4/20/16 date of hearing.

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

Ricky Reetz,

Petitioner,

vs.

NO: 11 WC 25450

17IWCC0059

Winston Towers II,

Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b)/8(a) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of medical, causal connection, prospective medical, 19(d) 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 1, 2016 is hereby affirmed and adopted.

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

17IWCC0059

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 $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 31 2017

Mario Basurto

David L. Gore

Stephen Mathis

MB/mas
o:1/19/17
43

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

REETZ, RICKY
Employee/Petitioner

Case# **11WC025450**

17IWCC0059

WINSTON TOWERS II
Employer/Respondent

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

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

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

0013 DUDLEY & LAKE LLC
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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)/8(a)

Ricky Reetz
Employee/Petitioner
v.
Winston Towers II
Employer/Respondent

Case # 11 WC 025450

An *Application for Adjustment 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 **3/11/2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☐ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ Is Petitioner entitled to any prospective medical care?
L. ☐ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☐ TTD
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☒ Is Respondent due any credit?
O. ☒ Other **§ 19(d) – Injurious Practices**

FINDINGS

On the date of accident, **May 27, 2011**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$66,595.96**; the average weekly wage was **$1,280.50**.

On the date of accident, Petitioner was **52** 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 **$44,065.35** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$44,065.35**.

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

ORDER

Respondent shall authorize and pay for the revision add-on spinal fusion procedure from L4-S1 as recommended by Dr. Bernstein in his letters of November 11, 2013, November 19, 2013 and as testified about in his Evidence Deposition of September 2, 2015, along with all related services, provided that Petitioner quits smoking, entirely. Additionally, Respondent shall authorize and pay for the continuing palliative treatment provided by Dr. Xia prior to the fusion surgery.

Respondent shall pay Petitioner TTD benefits of $853.67/week for 51-6/7 weeks for the time period of 11/28/12 through 11/25/13, inclusive. Based upon the Parties stipulation as to AWW and the proofs, there has been an underpayment of $203.41 in TTD benefits.

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

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

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

Signature of Arbitrator

June 1, 2016
Date

ICArbDec19(b)

JUN 1 - 2016

STATEMENT OF FACTS

Petitioner was employed by Respondent as head of maintenance. He worked for Respondent for 35 years. His job duties include physical and non-physical work. He could delegate the more physical jobs to his subordinates. He was in charge of a 218 unit condominium and he had three co-workers that were subordinate to him. Petitioner received monetary pay and the use of a condo unit as compensation for his employment. Petitioner pays $100.00 per month to rent the condo, because it is a 2 bedroom unit and his compensation package contemplates the use of a one bedroom unit. The Parties agreed that the correct Average Weekly Wage was $1,280.50, via a Stipulation that was filed herein on March 23, 2016.

Prior to his May 27, 2011 work accident, Petitioner was in good shape from a physical standpoint. He had no real problems with his low back and certainly was not restricted from work regarding his low back. He was able to fully function in his job as head of maintenance for the Respondent prior to the work accident.

The Parties stipulated that Petitioner sustained accidental injuries which arose out of and in the course of his employment by Respondent on May 27, 2011. He was up on a ladder and twisted a valve, causing injury to his back. He felt immediate low back pain.

As a result of the work injury, he sought medical treatment from Dr. Steven Sclamberg, who is with Orthopedics of North Shore. Dr. Sclamberg recommended physical therapy and ultimately referred Petitioner to Dr. Charles Slack. Petitioner received physical therapy and several lumbar injections, none of which provided relief. Petitioner was ultimately referred to Dr. Theodore Fischer at Illinois Bone & Joint Institute. Petitioner's treatment with Dr. Fischer included a lumbar fusion at the L4-5 level on November 28, 2012. Subsequently, Petitioner was diagnosed with L4-L5 psuedoarthrosis. (PX 3, 4 & 5)

Petitioner testified that he never recalls Dr. Fischer telling him to stop smoking before or after his lumbar fusion. Petitioner has a smoking history of 1 ½ packs per day for more than 30 years. Dr. Fisher's records show that, as would be expected, Petitioner was advised to stop smoking.

Following surgery, Petitioner was sent by Respondent for a §12 examination by Dr. Avi Bernstein on August 12, 2013. He was informed by Dr. Bernstein that he had a failed fusion as well as a drop foot condition in the right foot. Subsequent to the IME, Dr. Bernstein became Petitioner's treating physician. Dr. Bernstein's diagnosis is: "known psuedoarthrosis at L4-L5 and advanced degenerative disc disease at L5-S1. Dr. Bernstein believes that Petitioner requires a revision add-on fusion, L4-S1. After discussing in detail the pros and cons of this surgery, Petitioner testified that he, in fact, would like to undergo the surgery proposed by Dr. Bernstein. He testified that he would like to be pain free and would like to be able to work without the need for medications or a back brace.

Petitioner testified that following the lumbar surgery that occurred on November 28, 2012, his low back condition has not improved. In fact, he still has low back pain with pain radiating down the right leg. He also has experienced foot drop symptoms in his right foot following surgery. The right drop foot condition essentially leads him to drag or shuffle his right foot when walking. This was something new since the surgery.

Petitioner last saw Dr. Bernstein in May of 2015. At that time, the plan was for Petitioner to undergo a two level fusion at the L4-5 and L5-S1 levels. Petitioner reiterated his desire to have the surgery. He is simply waiting for approval at this point in time. (PX 2)

Petitioner has also received treatment from a pain management doctor, Dr. Tian Xia. He has been seeing Dr. Xia since August of 2014 and receives medications including Norco (4 times a day), Tramadol (3 times a day), Gabapentin (2 times a day) as well as muscle relaxers (3 times a day). (PX 7) He also applies a salve to his low back. In addition to the pain medications, Petitioner requires the use of a back brace when he works. If Petitioner goes off of his pain medications, his pain increases, making work much more difficult.

Petitioner was off work and paid TTD benefits of $699.45/week beginning November 27, 2012. Petitioner returned to work on November 26, 2013. Petitioner needed to return to work in order to continue living in the condo. For several months thereafter, until February 11, 2014, he received his weekly TTD check. Petitioner felt that this was money due and owing to him. At trial, Respondent sought a credit for this overpayment.

Petitioner's testimony regarding his smoking was not very clear. Initially, he felt he reduced his smoking from essentially two packs to one pack a day in July of 2015. He later testified that this could actually be a later date. Petitioner does know that in 2016 he has reduced his cigarette consumption to one pack per day in anticipation of having further lumbar fusion surgery. Dr. Xia's chart of January 7, 2016 says that Petitioner has quit smoking (as of December of 2014!). (PX 7) Petitioner also testified that he would quit smoking, per the direction of Dr. Bernstein, once his surgery is scheduled.

Petitioner's PCP, Dr. Bajgrowicz, charted that Petitioner was smoking 2.0 PPD for 30 years in a note of 9/2/2015, when Petitioner was seen for a bee sting. The remainder of the PCP's EMR records do not mention smoking, including a visit for a URI/pharyngitis on 2/10/2015. (RX 6)

Aida Kovacevic testified on behalf of Respondent. She works for Chicagoland Community Management, which is the managing company for Respondent. She has been the property manager since May of 2014. She authenticated Respondent's Exhibit No. 4, which is the work attendance record for the Petitioner for the time period of 11/1/2013 to 10/20/2015. She considers herself Petitioner s supervisor. Although she knows what Petitioner does on a regular basis, she does not actually see him perfor n his work duties very much. She did say that Petitioner has good work attendance. Moreover, she believes tha Petitioner is trustworthy and hardworking.

The evidence deposition of Avi Bernstein, M.D. was submitted as Petitio er's Exhibit 1. Dr. Bernstein is a board certified orthopedic surgeon, exclusively treating conditions related to the spine. He performs between 200 and 250 spine surgeries per year. In this case, he became involved as an inde pendent medical examiner and,

subsequently, became Petitioner's treating physician. Dr. Bernstein reviewed many records, including those from Dr. Fischer, Dr. Sclamberg, St. Joseph's Hospital, Open MRI of Chicago, Lakeshore Open MRI, and Total Rehab as well as IME reports from Dr. Alexander Ghanayem and Dr. Kevin Walsh. Benstein first saw Petitioner on August 12, 2013 for an independent medical examination. In connection with the exam, he also reviewed a CT scan from June 18, 2013, as well as a lumbar MRI of August 15, 2011. He understood that Petitioner underwent a lumbar surgery on November 28, 2012 in the nature of a posterior decompression and fusion at the L4-5 levels. Dr. Bernstein's assessment of Petitioner as of the August 12, 2013 visit was status post lumbar fusion. Petitioner had a failed fusion at the L4-5 level; Petitioner had a partial foot drop on the right side as a complication of the lumbar fusion; as well as a severely degenerated disc at the L5-S1 level that was a potential contributing pain generator. A myelogram and post-myelogram CT confirmed the Psuedo arthrosis. Benrstein believes that the post-surgical CT scan clearly identifies a failed fusion.

It is Dr. Bernstein's opinion that the L5-S1 level should have been addressed during the initial surgery because it was clearly a pathologic level. In his opinion, it was silly to leave this level untreated. He believes that the pain complaints made by Petitioner are attributed to the L5-S1 level. He stated that if the L5-S1 level was not treated initially in the fusion, the stress transfer to that abnormal level alone can cause severe pain. It is Dr. Bernstein's opinion that the L5-S1 level and its problems are a combination of a pre-existing condition superimposed by the work accident. Additionally, the stressors from the lumbar fusion contribute to the problem. It is his opinion that the lumbar fusion Petitioner underwent in November of 2012 transferred stress to the L5-S1 level. Dr. Bernstein believes that even though the fusion failed, the level fused is much stiffer and would transfer stress to the adjacent levels. Dr. Bernstein believes that the pre-existing condition in Petitioner's lumbar spine was aggravated as a result of the work accident. He also believes Petitioner suffered a disc herniation at the L4-5 level as a direct result of the work accident.

As far as the partial foot drop is concerned, the L5 nerve root is the nerve root that would cause the foot drop. The L5 nerve root leaves through the L5-S1 level. Prior to the work accident and prior to the lumbar fusion performed by Dr. Fischer, Petitioner never experienced foot drop issues.

Dr. Berstein believes that Petitioner is highly motivated and a candidate for further lumbar surgery to reduce pain and increase function. The surgery Dr. Bernstein proposes is in two stages. The first stage is going through the belly, basically removing bone graft at the L4-5 disc space and putting a cage in front of the spine, moving down to the L5-S1 level and heightening that disc space by putting a cage into the disc space. The second stage of the operation would be coming from the back side, pulling out the hardware at L4-5 and then putting in fresh hardware from L4-5 through S1. This would bridge both levels by adding more bone graft posteriorly. This approach would give Petitioner the highest likelihood of fusion success. The recovery for a one versus two level fusion as well as the post-surgical care would be no different. If there was only a one level fusion performed at L4-5, the right foot drop from the L5 nerve root would be a problem that would be unaddressed. The two level fusion, including the L5-S1 level will address the right foot drop problem. If only one level is fused at L4-5, it is likely the Petitioner would continue to have foot drop. If the L5-S1 level is the current pain generator and if only a L4-L5 fusion is done, Petitioner will still have pain complaints. If surgery is to be performed, the L5-S1 pathology should be addressed.

Since his last visit, Petitioner continues to take pain medication and was still in need of the two level fusion that Dr. Berstein is recommending. If Petitioner does not undergo the recommended surgery, the condition he presented to Dr. Bernstein in May of 2015 would be permanent and would not get any better. Without surgery, the Petitioner would have difficulty continuing to perform his job and would have difficulty in life in general.

Currently, Petitioner sees Dr. Tian Xia, who is a pain physician. Dr. Bernstein finds it reasonable for Petitioner to continue to treat with Dr. Xia. Dr. Bernstein confirms that the initial surgery performed by Dr. Fischer was directly related to the work accident. The foot drop that Petitioner experiences is a direct result of

complications from the surgery performed by Dr. Fischer. Dr. Bernstein testified that there is a correlation between smoking and the advancement of degenerative disc disease. According to Bernstein's chart, Petitioner had quit smoking in January of 2015. There is an increased risk of a fusion failing to heal if the patient continues to smoke cigarettes. Petitioner's continued smoking after the first fusion and after being told to cease smoking could have resulted in the psuedoarthrosis. (PX 1)

Petitioner also underwent §12 examinations by Dr. Alexander Ghanayem and Dr. Kevin Walsh at Respondent's request. (RX 1, 8) Dr. Ghanayem thought that the accident at least aggravated Petitioner's low back condition and later concurred with the proposed L4-L5 decompressive procedure with fusion. (RX 1) Dr. Walsh concurred that the accident aggravated Petitioner's low back at L4-L5 and with the diagnosis of psuedoarthrosis. Dr. Walsh thought that this condition could be remedied by a redo fusion at L4-L5. An extension of the fusion to L5-S1 would not be unreasonable, but it would not be related to the accident. (RX 8)

The evidence deposition of Kevin Walsh, M.D., was submitted as Respondent's Exhibit 8. He is a board certified orthopedic surgeon. Dr. Walsh is a general orthopedic surgeon and performs surgery on the shoulders, elbows, wrists, knees and hips. He last did spine surgery about 10 years ago. He saw Petitioner for an IME on December 26, 2013. He was aware of Petitioner's work related accident of May 27, 2011. Upon his review of records, he identified evidence of a disc protrusion/herniation at the L4-5 level. Petitioner reported that he smokes a pack of cigarettes a day at the time of the IME exam. Smoking has a deleterious effect on discs. Smokers have a higher risk of low back pain and disc herniations. Failed fusions can result partially from smoking. Petitioner underwent lumbar surgery on November 28, 2012 (L4-L5 fusion with instrumentation). Dr. Walsh believes that adjacent level stress from a fusion usually takes 10 years or greater from the date of surgery to manifest. Smoking increases a patient's risk for a non-union fusion. Upon review the post-surgical CT scan Walsh identifies evidence of pseudoarthrosis as well as degenerative changes at the L5-S1 level. Upon physical exam the Petitioner had no evidence of sciatica. Dr. Walsh's diagnosis at the time of the IME exam was: lumbar strain, spondylolisthesis, lumbar spinal stenosis, status post L4-L5 posterolateral fusion,

pseudoarthrosis at fusion site and degenerative disc disease at L5-S1. The lumbar sprain and the aggravation of the spondylolisthesis at L4-5 was, in Walsh's opinion, related to the work accident. He believes the L5-S1 condition is degenerative and not caused by the work accident. There is no evidence that the accident aggravated or accelerated the L5-S1 level pathology. He understands that a two level fusion was proposed by Dr. Bernstein. However, Dr. Walsh feels that it is reasonable to proceed with a revision fusion at L4-L5 as a result of the work accident because the patient did have evidence of a non-union, pseudoarthrosis at the L4-L5 level. It would be reasonable to revise the L4-L5 level because of the failure of the fusion. It is also his opinion that the L5-S1 level pathology, was not causally related to the work accident and the L5-S1 level was not injured in the work accident.

On cross-examination, Dr. Walsh testified that he does about 100 IMe's per year. Dr. Walsh is a general orthopedic surgeon and does not perform spine surgery. He would not hold himself out as a specialist in spine surgery. He would refer spine surgery patients to a colleague in his own group. The last office note he has from Dr. Bernstein's office was dated November 19, 2013. He has not reviewed any additional records from Dr. Bernstein following the IME. He has not reviewed any of the records from the pain management doctor, Tian Xia, M.D. He does not know what, if any, pain medication Petitioner had taken in 2014 and 2015. He agrees with one of the other Respondent IME physicians, Dr. Alexander Ghanayem, that the initial surgery performed by Dr. Fischer was causally related to the work accident. He agrees that there is a failed fusion at L4-5. He believes it would be reasonable for Petitioner to undergo a revision at the L4-L5 area. He agrees that if the Petitioner is on pain medication for two years and his surgeon feels L4-L5 and L5-S1 are the generators of pain, then it is certainly reasonable to perform a two level fusion, if the surgeon believes the pain is coming from those two levels. He does not doubt that Dr. Bernstein accurately described a right foot drop upon his examination. He just did not find the same thing upon his own examination of Petitioner. Although he doesn't believe there is imaging evidence of nerve damage, he does concede that the nerve emanating from the L5-S1 level would innervate the dorsiflexion of the ankle. One of the possible causes of a foot drop would be the L5

nerve root. The L5 nerve root potentially passes through the L5-S1 space. The foot drop complaint would be a new complaint following the surgery. Foot drop is a potential complication from L4-L5 fusion surgeries. Dr. Walsh agrees that if a fusion was only done at the L4-5 level, this could put added stress on the L5-S1 level. (RX 8)

The reports and records from Dr. Charles Slack were introduced as Petitioner's Exhibit 's 3 and 4. Dr. Slack's records clearly verify that Petitioner injured his lumbar spine as a result of the work accident. Ultimately, Dr. Slack referred Petitioner to Dr. Theodore Fischer. Dr. Fischer's surgical report is included in Petitioner's Exhibit 4. Dr. Fischer ultimately performed lumbar surgery on November 28, 2012. His operative report is contained in Petitioner's Exhibit 4. The surgical report notes that the risks of surgery "include but are not limited to blood loss, infection, nerve damage, dural tears, adjacent segment disease particularly at the L5-S1 level where he has degeneration already..." Dr. Fischer's records demonstrate that Petitioner was smoking and that he was advised of the detrimental effects of smoking and the possibility of failing to cease smoking leading to a nonunion requiring more surgery. (PX 4)

Petitioner's most recent medical treatment comes from a pain management physician, Dr. Tian Xia from Integrated Pain Management. These records are included in Petitioner's Exhibit 7. Petitioner has been under the care of a pain management doctor and has been taking pain medication starting in August of 2014 through the date of hearing.

Respondent disputes causal connection and asserts a §19(d) defense based upon Petitioner's smoking. Respondent also disputes causal connection regarding the L5-S1 portion of the proposed fusion, based upon the opinion of Dr. Walsh that this level of Petitioner's spine was not affected by the accident or the first fusion procedure in any way (not causally related, no acceleration, aggravation or exacerbation). Per Dr. Bernstein's November 19, 2013 chart, Respondent's carrier will only approve the revision of the posterior L4-L5 fusion. (PX 1, 2)

CONCLUSIONS OF LAW

The Arbitrator adopts the above Statement of Facts in support of the Conclusions of Law set forth below.

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

The Arbitrator finds that Petitioner's current condition of ill-being regarding his lumbar spine (status post lumbar strain and herniated disc at L4-L5 with aggravation of DDD leading to the L4-L5 fusion performed by Dr. Fischer with residual foot drop and psuedoarthrosis at L4-L5 and symptomatic DDD at L5-S1, leading to the recommended revision and add-on fusion L4-S1 offered by Dr. Bernstein) to be causally related to the injury.

The Arbitrator bases this decision on the credible testimony of Petitioner, the medical records and the credible and persuasive opinions of Dr. Bernstein. Dr. Bernstein is a well-regarded spinal surgeon, performing 200-250 spinal surgeries per year. His opinion is given more weight than Dr. Walsh, a general orthopedist who does not currently perform spinal surgery.

While Petitioner's smoking has likely had a negative effect on his spinal health and probably contributed to the failure of the fusion done by Dr. Fischer, the Arbitrator does not find that it was sufficient enough to become a superseding intervening cause of Petitioner's current lumbar spine condition, thus breaking the causal connection chain between the injury and Petitioner's current condition of ill-being.

WITH RESPECT TO ISSUE (K), IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator finds that Petitioner is entitled to prospective medical care as proposed by Dr. Benrstein in his deposition (Anterior/Posterior Revision add-on fusion L4-S1), along with all related services (including, obviously, a vascular surgeon assist given the anterior approach and Petitioner's prior surgical history) based upon the Arbitrator's finding regarding causation, above and the credible and persuasive testimony of Dr. Bernstein. Dr. Fischer tried to be conservative and only fuse L4-L5 (although the DDD condition of L5-S1 was appreciated) and the fusion failed. Dr. Bernstein's opinion that both

L4-L5 and L5-S1 should be addressed in any future procedure is persuasive and correct. If Petitioner would not have had the injury, the first fusion and the sequelae of the foot drop and the psuedoarthrosis would likely not have occurred. The procedure offered by Dr. Bernstein gives Petitioner the best chance for a better quality of life and to be able to continue to do his job.

The Arbitrator makes this finding on the condition that Petitioner stop smoking cigarettes. If Petitioner fails to do so, he is courting disaster and faces the likelihood of another failed fusion after undergoing major surgery with all of the risks, pain, disability and costs associated therewith. The Arbitrator does believe that Petitioner genuinely wishes to undergo the L4-S1 A/P fusion and will stop smoking to try to obtain a good result. Dr. Bernstein believes that Petitioner is highly motivated to receive an increase in function and relief of pain. Petitioner will need to stop smoking to have the best chance at a good outcome from the proposer surgery. If Petitioner fails to stop smoking, then Respondent should decline authorization of the surgery and file a §19(d) Motion.

Given the Arbitrator's findings on causation and on this issue, Petitioner is entitled to reasonable continued palliative care from Dr. Xia in order to alleviate his failed back surgery symptoms.

WITH RESPECT TO ISSUE (N), IS THE RESPONDENT DUE ANY CREDIT. THE ARBITRATOR FINDS AS FOLLOWS:

Subsequent to the trail, the Parties entered a stipulation, agreeing on the AWW of $1,280.50. Accordingly, the correct TTD rate is $853.67. The proofs show that Petitioner is entitled to TTD from 11/28/2012 (the date of surgery) through 11/25/2013 (he returned to work on 11/26/2013), a period of 51-6/7 weeks. Petitioner was paid $44,065.35 in TTD benefits (RX 2). The amount of TTD owed is $44,268.76. Accordingly, Respondent is not due a credit and does owe Petitioner $203.41 in back TTD.

WITH RESPECT TO ISSUE (O) §19(d) INJURIOUS PRACTICES, THE ARBITRATOR FINDS AS FOLLOWS:

Given the evidence adduced, the Arbitrator finds that Petitioner did not engage in insanitary or injurious practices within the meaning of §19(d) of the Act. Petitioner's continued smoking of cigarettes after undergoing spinal fusion surgery was not a good choice, but the Arbitrator does not find that a reduction or suspension of compensation is appropriate.

STATE OF ILLINOIS)
) SS.
COUNTY OF PEORIA)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Daniel Painter,

Petitioner,

vs.

NO: 10 WC 32947

Marquette Heights Fire And Rescue,

Respondent,

17IWCC0060

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of medical, prospective medical, 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 June 7, 2016 is hereby affirmed and adopted.

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

17IWCC0060

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 3 1 2017

MB/mas
o:1/5/17
43

Mario Basurto

David L. Gore

Stephen Mathis

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

PAINTER, DANIEL
Employee/Petitioner

Case# **10WC032947**

17IWCC0060

MARQUETTE HEIGHTS FIRE AND RESCUE
Employer/Respondent

On 6/7/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.43% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0252 HARVEY & STUCKEL
DAVID W STUCKEL
101 S W ADAMS ST SUITE 600
PEORIA, IL 61602

0075 POWER & CRONIN LTD
ROBERT E LUEDKE
900 COMMERCE DR SUITE 300
OAKBROOK, IL 60523

17IWCC0060

STATE OF ILLINOIS)
)SS.
COUNTY OF PEORIA)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

DANIEL PAINTER,
Employee/Petitioner

v.

MARQUETTE HEIGHTS FIRE AND RESCUE,
Employer/Respondent

Case # 10 WC 32947

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Maureen Pulia**, Arbitrator of the Commission, in the city of **Peoria**, on **5/17/16**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **6/29/10**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$50,104.08**; the average weekly wage was **$963.54**.

On the date of accident, Petitioner was **46** 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 **$7,213.58** for TTD, **$00.00** for TPD, **$00.00** for maintenance, and **$00.00** for other benefits, for a total credit of **$7,213.58**.

Respondent is entitled to a credit of **$00.00** under Section 8(j) of the Act.

ORDER

Respondent shall pay reasonable and necessary medical services for an arthroscopy to determine whether or not he would be a candidate for a transplant, and then if so, a medical meniscal allograft transplantation, to be performed by Dr. Cole, as provided in Sections 8(a) and 8.2 of the Act.

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

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

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

Signature of Arbitrator

6/1/16
Date

ICArbDec19(b)

JUN 7 - 2016

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

Petitioner, a 46 year old fire and rescue volunteer, sustained an accidental injury to his left knee that arose out of and in the course of his employment by respondent on 6/29/10. Petitioner has worked for respondent for 20 years. Petitioner gets no compensation for this position. In addition to this volunteer position with respondent, petitioner had concurrent employment with Heritage Buick, as a Service Technician, where he repairs and performs maintenance on vehicles.

On 6/29/10 petitioner and his squad answered an emergency call at a residence. Petitioner was the night shift captain at the time. He was also a trained EMT. When petitioner arrived at the residence the patient was in full arrest. Petitioner took over CPR from the police officer that had started it before his arrival. He and his squad moved the patient to the floor and continued CPR and performed BLS. Petitioner and his squad then lifted the patient, who weighed in excess of 500 pounds, onto a patient mover, that is used for larger patients. Six members of his squad tried to move the patient. Petitioner was at the head of the tarp. As the squad carried the patient through the house and out through the front door. As the squad was carrying the patient down the stairs of the porch, the weight of the patient mover shifted on the last step. Petitioner braced for the extra weight and felt a pop in his left knee. Petitioner experienced instant pain and a burning sensation in his left knee. Petitioner continued moving the patient to the gurney. Petitioner continued giving the patient CPR on the gurney and in the ambulance.

Once they arrived at the emergency room of the hospital petitioner went into the EMT lounge to get ice for his left knee. Petitioner reported his accident to the Deputy Chief that was also at the hospital. Petitioner did work the remainder of the day.

On 6/30/10 petitioner went to Prompt Care. An x-ray of the left knee revealed no acute fracture or dislocation. Small joint effusion was noted.

On 7/2/10 petitioner presented to Dr. Johnson at Midwest Orthopedics. Dr. Johnson diagnosed a left knee Grade II MCL sprain. He referred petitioner for physical therapy. He also order a hinged brace to provide added stability to the knee. Dr. Johnson was of the opinion that petitioner could continue to work as a service technician full-time, but would be unable to safely continue as a firefighter at this time.

On 7/16/10 petitioner began a course of physical therapy at Midwest Orthopedic Center. On 8/24/10 petitioner underwent an MRI of the left knee. The impression was complete tear of the junction of the body and posterior horn of the medial meniscus extending to the superior and inferior articular surfaces; chronic low grade sprain of the medial collateral ligament; acute partial tear of the anterior

cruciate ligament; small patellofemoral joint effusion with small medial and suprapatellar synovial plica; superficial venous varicosities in the subcutaneous fat at the posterior aspect of the knee; minimal bone marrow edema in the medial aspect of the medial tibial plateau. Petitioner continued in physical therapy until September of 2010. On 8/30/10 petitioner followed-up with Dr. Johnson. He confirmed that petitioner had a tear in the posterior horn of the medial meniscus as well as a low grade sprain of the medial collateral ligament and partial tear of the ACL. They discussed injections versus surgery. On 9/28/10 Dr. Johnson recommended surgical intervention because conservative care had failed.

On 10/19/10 petitioner underwent a left knee arthroscopy and partial medial meniscectomy performed by Dr. Johnson. Petitioner's post-operative diagnosis was left knee medial meniscus tear. Petitioner followed-up post-operatively with Dr. Johnson. This treatment included additional physical therapy. On 11/3/10 Dr. Johnson continued petitioner in physical therapy and restricted him to sedentary duty. On 11/22/10 petitioner reported that he was still struggling with left knee pain behind the knee cap. He reported frequent episodes of popping and severe pain behind his kneecap each day, especially on stairs. He reported that he was off work. Dr. Johnson ordered ongoing physical therapy and returned petitioner to work 11/30/10 with restrictions.

On 1/24/11 petitioner called Dr. Johnson. He requested a prescription for Norco because he returned to work he had been having trouble. Dr. Johnson told him he could only prescribe Ultram. On 2/14/11 petitioner returned to Dr. Johnson. Petitioner reported ongoing constant sharp, burning-type pain diffusely over the lateral aspect of the left knee. He also reported that his left knee occasionally feels like it will catch and give way. Dr. Johnson was of the opinion that petitioner's problems were more likely secondary from his patellofemoral joint than his meniscus. He continued petitioner on full duty. He prescribed an anti-inflammatory. On 3/28/11 petitioner reported that his condition was unchanged. He reported problems especially with stairs. He also reported swelling toward the end of the day. Dr. Johnson gave him home exercises and released him to full duty work. On 5/13/11 Dr. Johnson released petitioner from care.

On 7/19/11 petitioner called Dr. Johnson requesting additional treatment. Dr. Johnson said he would need authorization. Petitioner got authorization and returned to Dr. Johnson on 8/22/11. Petitioner reported ongoing increasing pain that was getting worse and worse. He reported that most of the pain is in the medial aspect of the knee. He stated that it is a constant aching type pain that significantly limits his activities. He denied any new injury. He reported mild intermittent swelling. Dr. Johnson ordered a repeat MRI.

On 10/7/11 petitioner followed-up with Dr. Johnson's PA for his left knee osteoarthritis. He reported continued difficulties. He rated his pain at a 7/10 diffusely throughout the knee. Dr. Johnson performed a Synvisc injection.

On 11/16/11 petitioner followed up with Dr. Johnson. Petitioner reported only minimal improvement with the Synvisc injections. Petitioner was still reporting diffuse pain over the knee. Petitioner reported an aching and burning sensation that is constant in nature and bothers him with sleep. Petitioner reported occasional catching and locking in the knee. Dr. Johnson did not recommend any further treatment. He released him on an as needed basis. Petitioner was restricted from climbing or stairs with his left knee.

On 10/29/12 petitioner completed a follow-up medical questionnaire. He indicated that his left knee condition was the same. He rated his pain at 7-8/10. He indicated that his pain was sharp, stabbing and burning. He reported that his pain comes and goes. He reported weakness, swelling, locking/catching, and giving way. Petitioner indicated that he performs a home exercise program and wears a brace.

On 2/14/13 petitioner presented to Dr. Brian Cole for an evaluation of his left knee. Petitioner gave a history of the accident and treatment to date. Petitioner complained of persistent medial sided pain, that bothers him with weightbearing activities and daily living activities. He stated that he cannot return to work for respondent with the pain. Dr. Cole examined petitioner and ordered a repeat MRI.

Petitioner underwent an MRI of the right knee on 4/8/13. The impression was full-thickness articular cartilage fissure of the medial patellar facet with no associated subarticular bone marrow edema or subchondral cyst formation; and truncated appearance of the posterion horn of the medial meniscus, nonspecific, and may reflect postsurgical changes.

On 4/8/13 petitioner returned to Dr. Cole. Dr. Cole was of the opinion that it is less likely that petitioner would be an ideal candidate for meniscal transplant due to his advanced age and BMI. He was of the opinion that complete resolution of petitioner's pain may be best indicated with a partial replacement. Dr. Cole referred petitioner to Dr. Sporer for evaluation regarding this procedure.

On 7/31/13 petitioner presented to Dr. Sporer for evaluation of his left knee. Petitioner reported that the cortisone injection provided his mild relief, but the hyaluronic acid injection did not provide much in the way of relief. He rate his pain at a 6-7/10. Dr. Sporer examined petitioner and did not think he was a good candidate for a medial compartment arthroplasty. He noted that petitioner's articular

cartilage was well preserved. He recommended non-arthroplasty options for treatment. He recommended nonsteroidal anti-inflammatories, repeat intraarcticular injections. Dr. Sporer told petitioner he may develop degenerative changes in the future.

On 10/7/13 petitioner returned to Dr. Cole. Dr. Cole noted that petitioner had been failing conservative management. Dr. Cole told petitioner that it would be beneficial for him to continue to lose weight as he may be a meniscal transplant candidate, since he has failed all options. Dr. Cole performed a cortisone injection. Dr. Cole ordered a repeat MRI of the left lower extremity. He continued petitioner on full duty.

On 10/21/13 petitioner returned to Dr. Cole and reported that the injection on 10/7/13 only gave him a few days of relief. Dr. Cole noted that the MRI was unchanged from April. Dr. Cole recommended that petitioner undergo a meniscus transplantation. He believed petitioner was an appropriate candidate for this and he has failed all other options. He was of the opinion that the success rate is 70-75% and sometimes even 80%. Dr. Cole instructed petitioner to continue with strengthening and weight loss.

On 2/18/14 petitioner underwent a Section 12 examination performed by Dr. Preston Wolin, at the request of the respondent. Dr. Wolin examined petitioner and performed a record review. Dr. Wolin assessed status post medial meniscectomy with persistent pain. He found petitioner's condition causally related to the work episode on 6/29/10. He was of the opinion that petitioner was at MMI from the surgery Dr. Johnson performed, but not at overall MMI. Dr. Wolin was of the opinion that with respect to the meniscal allograft transplantation proposed by Dr. Cole, he was concerned because petitioner's BMI was over 30, and his use of alcohol potends negatively for postoperative pain control following this surgery. Until these issues are resolved he would be concerned about performing this procedure. Dr. Wolin was of the opinion that the postoperative MRI scan showed articular cartilage changes about the medial femoral condyle and/or medial tibial plateau, and these changes may mitigate against a good result. Dr. Wolin recommended that petitioner be managed with a medial unloading brace and weight loss, as well as a different type of hyaluronic acid. Dr. Wolin also recommended an FCE. He was of the opinion that petitioner's current restrictions are related to the work injury.

On 5/14/14 Dr. Wolin drafted a letter stating that there is a causal connection between the recommendation for meniscal allograft transplantation and the work episode of 6/29/10. However, he reiterated that he does not recommended a meniscal allograft transplantation. He did not recommend a formal weight loss program.

On 10/24/14 ALARIS denied authorization for left knee meniscus transplant. It was noted that the health of the petitioner's articular cartilage health was unknown and the patient was too old and too heavy. They recommended weight loss surgery over knee surgery. It was also noted that this procedure may delay his ultimate knee replacement.

On 12/1/14 petitioner returned to Dr. Cole for reevaluation of his left knee. Petitioner reported ongoing medial side knee pain with associated swelling and discomfort. Petitioner reported that he was working full duty with modification to his activities as a volunteer firefighter. Dr. Cole was of the opinion that petitioner was not an appropriate candidate for a total knee arthroplasty at that time because he had relatively preserved joint spaces with neutral alignment. Dr. Cole noted that petitioner had been working on his weight management over the course of the last year, losing greater than 36 pounds and reducing his BMI to below 30. Dr. Cole ordered an MRI for evaluation of the articular cartilage. Dr. Cole noted that since petitioner was now over 50, and per criteria is becoming a less ideal candidate for a medial meniscus allograft transplantation. Dr. Cole was of the opinion that there may be a consideration of a partial knee for evaluation of the articular cartilage, based on the results of the MRI. Dr. Cole noted that recent x-rays showed some minimal joint space changes. Petitioner was released to full duty work.

On 4/20/15 petitioner returned to Dr. Cole. Petitioner continued to complain of medial-sided knee pain associated with swelling and discomfort. Dr. Cole noted that petitioner was seen by an arthroplasty specialist and was currently not a candidate for a joint reconstruction. X-rays showed an intact ACL and PCL and a meniscectomized state of medial compartment. The overall cartilaginous surfaces throughout the knee were well preserved. Dr. Cole believed petitioner was a good candidate for a meniscal allograft. He noted that petitioner has a good mechanical alignment with well preserved articular cartilage based on his MRI. Dr. Cole noted minimal narrowing of the medial compartment as based on his flexion views of the knee on x-ray. Dr. Cole noted that petitioner is not a candidate for a total knee that has been confirmed by a reconstruction specialist. He noted that petitioner's BMI was now 28. He was of the opinion that since petitioner had injections in the past that provided him some relief it is clear that the pain is intraarticular. Dr. Cole was of the opinion that petitioner is clearly a candidate for medial meniscal allograft transplantation which would provide him considerable pain relief and allow him to continue with improved pain free existence. He noted that literature indicates a 70-85%, good to excellent result with reliable alleviation of pain symptoms. He continued petitioner on full duty work. Dr. Cole performed another injection.

On 7/28/15 the evidence deposition of Dr. Cole was taken on behalf of the petitioner.Dr. Cole opined that the medial joint line pain in petitioner's left knee was a consequence of the previous meniscectomy he had undergone. Dr. Cole recommended a new arthroplasty to determine whether or not he would be a candidate for a transplant, and then they would be poised to do the transplant if petitioner was a candidate. Dr. Cole opined that the goal of the allograft is to help provide a washer and a load absorbing cushion inside the knee to reduce load and pain. Dr. Cole opined that this surgery could delay the need for a knee replacement, and enable petitioner to have a more normal life that he currently has, due the pain he suffers from. Dr. Cole opined there were no other forms of orthopedic treatment that he believes are reasonably available that would yield the same benefits as an allograft. Dr. Cole opined that arthritis would be an indicator for a partial knee replacement. Dr. Cole opined that petitioner does not have degenerative joint disease in his left knee. Dr. Cole opined that criteria for a medial meniscus allograft transplant includes being under 55 and physically active or desire to be physically active, persistent pain, stable ligaments and normal alignment of the knee, minimal or no arthritis in the knee, and not obese. Dr. Cole opined that petitioner was no longer obese and does not have arthritis. Dr. Cole was of the opinion that the petitioner has cartilage deterioration in the left in one spot, the medial patella facet. Dr. Cole opined if the petitioner was never pain free after his meniscectomy and continued to complain of symptoms in his left knee on a regular and routine basis from when he was released by Dr. Johnson until he saw him in 2013, then petitioner's current condition of ill-being as it relates to his left knee is causally related to the original injury.

On 8/18/15 Dr. Wolin performed a repeat examination. Petitioner reported that his knee pain was the same. Petitioner reported that he had lost weight and no longer drinks alcohol. Petitioner was wearing a hinged brace for relief. Dr. Wolin noted that several of his concerns regarding weight apparent alcohol intake had been resolved since his first exam in 2014. However, Dr. Wolin remained concerned about the use of meniscal allograft transplantation. He noted that petitioner's age of 52 was a contradiction for surgery. He noted that the reasons for the age limit is that over time additional contraindications to the procedure are likely to occur and include, the increased likelihood of chondral changes about the femur and tibia, and the likelihood of alteration of alignment over time with the knee assuming a varus attitude. Dr. Wolin was of the opinion that petitioner has or may have the contraindications that include age; alignment was not normal; possible chondral changes since last MRI 2 years ago. Dr. Wolin agreed with Dr. Cole that meniscal allograft transplantation does have a good success rate. However, he believed that percentage is in patients who do not have the contraindications he has.

On 11/10/15 Dr. Cole ordered another hinged brace for petitioner's knee.

On 12/23/15 the evidence deposition of Dr. Wolin was taken on behalf of the respondent. Dr. Wolin was of the opinion that petitioner's pain is related to the loss of his meniscus and this is related to the injury on 6/29/10. Dr. Wolin was of the opinion that the MRI in April of 2015 showed thinning in the medial compartment of the articular cartilage, although he did not review the actual films. He noted that her could not form an opinion on that state of petitioner's articular cartilage unless he viewed the films of the MRI. Dr. Wolin opined that petitioner needs an athroplasty. Dr. Wolin noted that he was aware that the AAOS, which he is a member of, say that people younger than 55 may be eligible for the meniscal transplant. On cross-examination Dr. Wolin admitted that a 4 millimeter joint space, which petitioner has is a probably a good space when you are looking at a meniscal transplant. Dr. Wolin was of the opinion that if petitioner had a full knee replacement he would have problems with bending, stooping, squatting , kneeling, etc., and if he needed these activities for his job as a mechanic and fireman it is unlikely he could return to his regular duties in either job. It was noted during the deposition that Dr. Cole had stated that he would need to look at a new MRI to make sure everything was the same. Dr. Wolin said a partial or total arthroplasty or a high tibial osteotomy are possible procedures. He was of the opinion that a high tibial osteotomy would provide petitioner the ability to return to work as good or better than a meniscal allograft transplantation.

On 5/4/16 the evidence deposition of Dr. Stanley Katz, who performed the utilization review for the meniscal allograft transplantation procedure at the request of ALARIS, was taken on behalf of the respondent. Dr. Katz is a licensed orthopedic surgeon in Orange County, CA.Dr. Katz did not examined petitioner, but rather performed a record review on records through 5/14/14. Dr. Katz was of the opinion that petitioner never got better after then injury, even after the surgery. Dr. Katz was of the opinion that meniscal transplants are performed when strict guidelines are met, or the results are poor. Dr. Katz was of the opinion that the alignment of the knee needs to be more or less normal except for the torn meniscus, the patient should not be overweight and should not be over 45 years old. Dr. Katz believed that patients that were older tend to do worse, with increased levels of pain and stiffness following the surgery. Dr. Katz testified that he never discussed this procedure for petitioner with Dr. Cole. He stated that they were never able to get in touch. Dr. Katz testified that he still stands by his opinions that were in his report.

On cross-examination Dr. Katz testified that he applied the ODF guidelines and not the AAOS guidelines. He stated that he was not surprised that the AAOS approves a meniscal transplant surgery for

people who are younger than 55 and physically active. Dr. Katz testified that the ODG are some guidelines issued by a private organization called Work Loss Data Institute. Dr. Katz testified that he had not seen the report of Dr. Cole dates 4/20/15 which showed petitioner now had a BMI of 28, but agreed that a BMI of 28 is within the range of acceptable range for the medial transplant procedure. Dr. Katz admitted that his report indicated that petitioner's articular cartilage were pristine four years ago, and he had some mild arthritis. Dr. Katz was of the opinion that the varus misalignment could be cured during surgery by doing an osteotomy, which was different procedure than was being proposed. Dr. Katz testified that he has never done a meniscal transplant surgery. Dr. Katz testified that he did not have a clear picture of petitioner's articular cartilage, and agreed that it would be reasonable to do further tests that are necessary to examine the state of his articular cartilage. Dr. Katz testified that he did not see the report or film from the MRI on 4/20/15. Dr. Katz said an arthroscopy to see if the articular cartilage is appropriate if a varus stress x-ray did not give you the answers you were looking for. Dr. Katz was of the opinion that he would not exclude petitioner from a meniscal transplant surgery, if petitioner met all the ODG criteria except his age.

Petitioner testified that he wants to undergo the meniscal transplant surgery recommended by Dr. Cole. Currently, while working petitioner takes frequent breaks, and asks for help with certain aspects of the job he cannot complete. Petitioner testified that his pain is almost constant now. Petitioner stated that he has a new brace and takes Advil. Petitioner also wears an ice pack at night and on weekends. The brace petitioner currently wears everyday is the one Dr. Cole ordered. Petitioner testified that his knee is swollen at the end of the day. He denied any swelling and pain before 6/29/10, and any other injuries after that. Petitioner testified that he used to weigh 255 pounds, and now weighs 215.

F. IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY?

Petitioner claims his current condition of ill-being as it relates to his left knee is causally related to the injury he sustained on 6/29/10. Respondent claims there is no causal connection between petitioner's left knee and the injury on 6/29/10 after he was released from care on 5/13/11.

Multiple opinions regarding the issue of causal connection were offered into evidence. On 2/18/14 Dr. Wolin, respondent's examining physician, opined that petitioner's condition of ill-being as it relates to petitioner's knee is casually related to the episode at work on 6/29/10. Dr. Cole opined that if petitioner was never pain free after his meniscectomy and continued to complain of symptoms in his left knee on a regular and routine basis from when he was released by Dr. Johnson until he saw him in 2013, then petitioner's current condition of ill-being as it relates to his left knee is casually related to the injury on

6/29/10. The arbitrator notes that petitioner credibly testified and reported to all doctors that his left knee continued to hurt after the meniscectomy. Even Dr. Katz, who performed the utilization review, was of the opinion that petitioner never got better after the injury, even after the surgery.

Based on the above, as well as the credible evidence, the arbitrator finds the petitioner's current condition of ill-being as it relates to his left knee is causally related to the injury on 6/29/10.

K. IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE?

Petitioner alleges that he is entitled to prospective medical care that includes an arthroscopy to determine whether or not he would be a candidate for a transplant, and then if so, a medical meniscal allograft transplantation performed by Dr. Cole. Respondent claims the petitioner is not entitled to this prospective medical care.

Following the failed partial medial meniscectomy performed by Dr. Johnson on 10/19/10, the petitioner continued with ongoing left knee pain. Petitioner continued to treat with Dr. Johnson through 10/16/11, and continued to complain that his left knee was getting worse.

After petitioner was released by Dr. Johnson he presented for an evaluation of his left knee on 2/14/13 when his left knee failed to improve. Dr. Cole examined petitioner and also had an MRI done. On 4/8/13 he was of the opinion that it was less likely that petitioner would not be an ideal candidate for a meniscal transplant due to his advanced age and BMI. He was of the opinion that he may be a candidate for a partial replacement. He referred petitioner to Dr. Sporer for evaluation.

On 7/31/13 petitioner presented to Dr. Sporer. Dr. Sporer did not think petitioner was a good candidate for a medial compartment arthroplasty. He noted that petitioner's articular cartilage was well preserved. On 10/7/13 Dr. Cole told petitioner that since he has failed all options, if he continues to lose weight he may be a meniscal transplant candidate. Dr. Cole was of the opinion that the success rate for a meniscus transplantation is 70-75% and sometimes even 80%.

On 2/18/14 Dr. Wolin was concerned about petitioner undergoing a meniscal transplantation because he was using alcohol and his BMI was over 30. He also believed the MRI showed articular changes about the medial femoral condyle and/or medial tibial plateau, and these changes may mitigate against a good result. Despite these findings he did opine that there is a casual connection between the recommendation for the meniscal allograft transplantation and the work injury on 6/29/10.

Respondent had a utilization review performed by Dr. Katz with respect to the recommended meniscal transplant. Dr. Katz denied authorization because petitioner's articular cartilage health was unknown, and petitioner was too old and too heavy.

On 12/1/14 petitioner followed up with Dr. Cole and his BMI was below 30. Dr. Wolin confirmed that petitioner had stopped drinking. On 4/20/15 Dr. Cole was of the opinion that petitioner had good mechanical alignment with well preserved articular cartilage based on his recent MRI. He believed petitioner was a good candidate for the meniscal allograft. He noted that petitioner's BMI on this date was 28.

During his deposition on 7/28/15 Dr. Cole recommended a new arthroplasty to determine whether or not petitioner would be candidate for a transplant, and if so, then he would proceed with the medial transplant. Dr. Cole opined that this surgery could delay the need for a replacement and enable petitioner to have a more normal life than he currently has, due to the pain he suffers from. Dr. Cole was of the opinion that the requirements for a medial meniscus allograft transplant are being under 55, physically active, or a desire to be physically active, stable ligaments and normal alignment of the knee, minimal or no arthritis in the knee, and not obese.

On 8/18/15 petitioner reported to Dr. Wolin that he no longer drinks and lost weight. Dr. Wolin noted that several of his concerns with respect to this surgery had been resolved. He still saw petitioner's age of 52 as a contraindication, as well as his abnormal alignment, and possible chondral changes, that he could not confirm. Dr. Wolin testified that he did not review the films of the MRI in April 2015 and therefore could not form an opinion on the state of petitioner's articular cartilage. He admitted that a 4 mm joint space, is probably a good space when considering a meniscal transplant. Dr. Wolin admitted that if a full knee replacement was performed petitioner would unlikely be able to return to his regular duties as a firefighter or mechanic.

Dr. Cole was of the opinion that the requirements for a medial meniscus allograft transplant are being under 55, physically active, or a desire to be physically active, stable ligaments and normal alignment of the knee, minimal or no arthritis in the knee, and not obese. Dr. Katz testified that he was following the guidelines of the ODG rather than the AAOS, and those are guidelines are issued by a private organization called Work Loss Data Institute. He noted that the ODG required the patient to be no older than 45 years old, and was not surprised that the AAOS approves the procedure for people younger than 55. Dr. Katz did not speak with Dr. Cole and did not review his report of 4/20/15 that showed petitioner met the BMI requirements for the procedure. He also admitted that petitioner's

articular cartilage was pristine 4 years ago. Dr. Katz admitted that he has never performed a meniscal transplant surgery. Dr. Katz opined that he could not exclude petitioner from a meniscal transplant surgery if he met all the ODG criteria except his age.

After considering the opinions of Dr. Wolin, Dr. Katz and Dr. Cole, the arbitrator finds the opinions of Dr. Cole the most persuasive. Petitioner is a volunteer firefighter and a service technician for a car business. Without surgery petitioner cannot return full duty to either job. Additionally, if petitioner underwent a knee replacement he most likely would not be able to return to work. Initially the concerns were that petitioner was too obese. Petitioner lost weight and met the weight requirement. Then there were concerns regarding his articular cartilage and alignment, which Dr. Cole, the only doctor that actually reviewed the actual films of the MRI in April of 2015, opined met the requirements for the meniscal transplant. The last requirement of age was also conceded. Even though Dr Katz was following the ODG guidelines that required someone under the age of 45, he admitted that if petitioner met the other requirements then he did not see petitioner's age, which was under 55, the AAOS requirement for the procedure, a barrier to undergoing the meniscal transplant. The arbitrator also finds it significant that Dr. Cole is the only doctor that has actually performed the requested procedure.

Based on the above, as well as the credible evidence, the arbitrator finds the petitioner is entitled to prospective medical care that includes an arthroscopy to determine whether or not he would be a candidate for a transplant, and then if so, a medical meniscal allograft transplantation. These procedures would be performed by Dr. Cole. The respondent shall pay all reasonable and necessary medical services related to these procedures pursuant to Section 8(a) and 8.2 of the Act.